University of Alberta

Analysis of the Concept of Ethical Sensitivity

by

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Dedication

Writing a dissertation affects those closest to you and deprives them of your time. I dedicate this work to my three precious sons: Chris, Sean, and Michael who have lived much of this effort with me, have listened to my excitement and fatigue, and have been proud of my success. This has meant so much to me.

I also dedicate the dissertation to my mother, Daisy McCoul, and my mother-in-law, Barbie M^{ac}Callum, for their investment of love and on-going support for me and my sons.

Abstract

Ethical sensitivity enables professionals to interpret and respond to the needs of their clients. Although integral to decision-making and excellent clinical care, the concept of ethical sensitivity is fraught with theoretical confusion. It has been described as a caring response, skill in identifying ethical dimensions of care, intuition regarding other's comfort and well-being, and a component of moral care. There was a need to clarify this concept, and to enhance its utility to research and practice.

The Morse Criterion-based method of concept analysis enabled exploration of ethical sensitivity within the postmodern critical social theory research tradition. The analysis was guided by an understanding of professional role as expressed in discursive interactions rather than as domination and control. Data were published literature from selected disciplines included for their accessibility, relevancy, and usefulness to the emerging conceptualization. Overt and covert assumptions underlying definitions of ethical sensitivity were explicated. The meaning, relevance, dimensions, and utility of the concept were examined. Level of maturity or readiness for research was determined using logical, epistemological, linguistic, and pragmatic principles. Analytical questions, formulated from comprehension, provided new insights. Questions included: Is ethical sensitivity innate or acquired? How do organizations foster ethical sensitivity? Scientific rigor was achieved through sample adequacy, depth of analysis, development of argument, intellectual rigor, validity of results, saturation of categories, and contribution to knowledge.

Ethical sensitivity was found to require exposure to suffering and vulnerability cues, uncertainty, and relationships characterized by the professional's receptivity,

responsiveness, and courage. Attributes (characteristics) of the concept that were identified were moral perception, affectivity, and dividing loyalties. Outcomes included integrity-preserving compromise, client comfort and well-being, and professional learning and transcendence.

Results of this concept analysis will provide a strong foundation for positioning future inquiry within a program of research to study ethical sensitivity. These results will provide insight and understanding about an essential aspect of professional decision-making influencing efficacy of care. They will contribute to disciplinary knowledge informing the design of person-led care and professional educational programs. The transdisciplinary scope of the research enhances visibility of the nursing contribution to knowledge pertinent to and shared by professional disciplines.

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This dissertation is the culmination of a developmental process that crossed five provinces and spanned four years during which I have been privileged to meet many new people and deepen relationships with others. I consider myself extraordinarily blessed to have had the opportunity, the resources, and support to undertake this study. I have been irrevocably changed in the process. I thank my New Brunswick colleagues and friends, learning colleagues at the International Institute of Qualitative Methodology and University of Alberta Faculty of Nursing, and my special friend and fellow doctoral student Tina Wilson for her kindness and constant belief in me that helped me to bloom following my uprooting from the Maritimes. Without the spontaneous caring from so many people in so many ways, I could not have thrived amid doctoral study.

I am deeply indebted to my supervisor, Dr. Janice Morse, who guided this remarkable quest to produce credible research. I have greatly appreciated her rigorous critique of my written work, her wisdom, her generosity, her humor, her caring for me as a person - not just a student, and her questions that both frightened and nudged me toward intense reflection, introspection, and transformation. She invigorated my thinking during conversations in her office, my study cubicle, and conferences in Edmonton, Prince Edward Island, and Illinois. I thank her for the numerous dialogues via e-mail when I began study with her as a distance student. There were surely times when she must have wanted to press the delete key and get on with other responsibilities.

I wish to express appreciation to my thesis committee: Dr. Wendy Austin for her support of my research idea and belief in my capability to write this dissertation; Dr. Barbara Russell for her enthusiasm and acute comments; Dr. Olive Young (my internal

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Introductory Chapter

INTRODUCTION AND OVERVIEW

This dissertation represents the output of a comprehensive program of doctoral study. The overall aim of the research was to explore the concept of ethical sensitivity as it is defined and used in the literature of nursing and other professional disciplines.

My motivation for conducting this doctoral research evolved from my Masters of Nursing (MN) research, my experience as a faculty member with teaching responsibilities for baccalaureate nursing students in the area of psychiatric-mental health nursing, and my independent practice as a nurse clinician providing long term therapy to women with eating disorders. A finding from the MN study was that women recovering from Anorexia Nervosa (AN) perceived their experiences with health services as traumatic rather than as healing. In my clinical practice and teaching, clients[1] and nursing students expressed this similar concern. It was also reported in professional literature (e.g., Bruch, 1974; Button & Warren, 2001). Despite professional expertise and good intentions, jeopardy was associated with the care and treatment of those with complex, poorly understood conditions (i.e., eating disorders). Given this perceived jeopardy was as much a threat to their well-being as the health challenge itself, it was important to explore and understand it further. I wanted to learn how to deal with this perception and the situations that give rise to it. To begin to find answers for how nurses and other professionals[2] might better address the moral complexities encountered in providing care and services, I

[1] The term "clients" refers to persons receiving care and services from professionals. The term "patients" may be used when referring to clients in health care contexts.

[2] The term "professionals" refers to members of professional disciplines (i.e., specialized branches of knowledge, each with a unique perspective for viewing and constructing knowledge about its phenomena of interest [Donaldson & Crowley, 1997/1978]). Professionals enact socially valued occupational roles of providing specialized care and services to benefit persons in need of such care and services.

first needed a clearer understanding of the quality of practice that enables professionals to accurately recognize and appropriately respond to the needs of those they serve. In the dissertation research, I focused on the concept of ethical sensitivity because the reported incidents concerned violations of the values (e.g., privacy, respect for dignity) contained in the Code of Ethics for Registered Nurses (Canadian Nurses Association, 2002).

Program of Research

This dissertation research is the beginning of a research program that will attempt to make a difference in the lives of those receiving professional care and services. In particular, I am interested in focusing on women who receive treatment in psychiatric - mental health settings and who challenge, and are challenged by, the health care system. The ultimate goal of the research program is to improve the standard of care for these persons if professionals are more knowledgeable and self aware of the ramifications of their actions.

I had designed the MN research based on my knowledge of issues faced by women with eating disorders. My credibility as a practitioner enabled me to access this traditionally hidden population in a province (New Brunswick) without specialized clinics for the care and treatment of those with eating disorders. My clinical skills and knowledge of this population allowed me to understand the input of the women who participated in the study. The MN research consisted of grounded theory to learn how women recover from AN. It resulted in the construction of a midrange theory involving the concept of self-development to explain women's recovering process (Weaver, 2001). I have been able to validate the theory and its utility in supporting the recovery of women from AN through discussion with both those who participated in the study and those who

subsequently have sought my help in clinical practice. The theory was further tested through a project to disseminate findings via a video production.

Although the implications of the MN study have begun to raise public and professional awareness (and impact in some way on the health care system that serves these clients), there was need for additional research to explore the relationship between women's perceptions of care and the ethical sensitivity of the professionals providing treatment services. This doctoral research, resulting in clarification of the concept of ethical sensitivity, is the first step toward responding to the need (see Figure I-1).

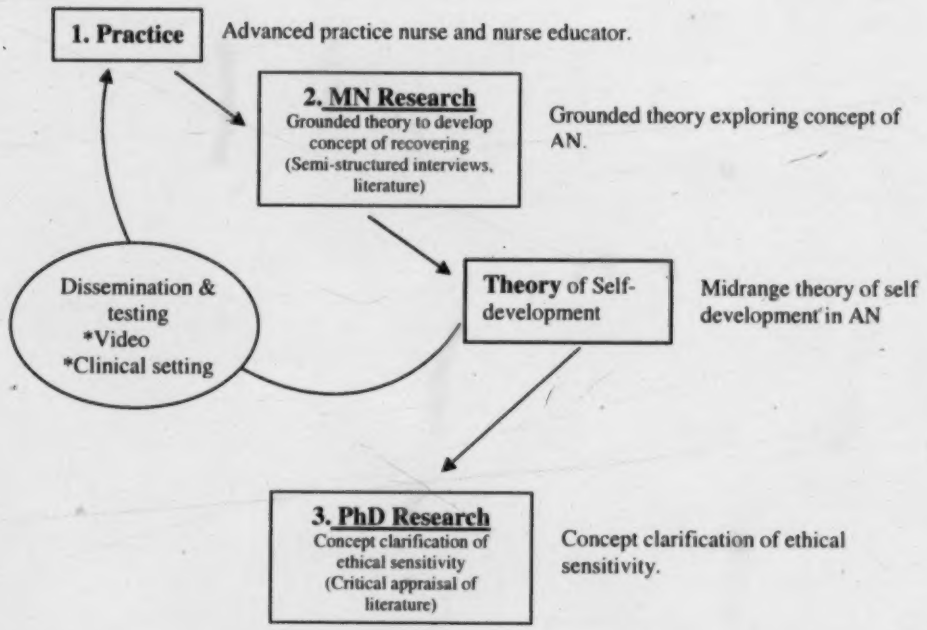
1. Practice
Advanced practice nurse and nurse educator.
2. MN Research
Grounded theory to develop concept of recovering
(Semi-structured interviews, literature)
Grounded theory exploring concept of AN.
Dissemination & testing
*Video
*Clinical setting
Theory of Self-development
Midrange theory of self development in AN
3. PhD Research
Concept clarification of ethical sensitivity
(Critical appraisal of literature)
Concept clarification of ethical sensitivity.

Figure I-1. Development of research program from MN to PhD studies.

Background for the Doctoral Research

To begin to understand ethical sensitivity, an extensive review of the literature pertaining to the topic was conducted. Briefly, the concept of ethical sensitivity was introduced to science by psychologist, James Rest (1982) to describe the first component of a four stage model of decision-making in professional practice. Ethical sensitivity was defined as professional capacity for recognizing and interpreting the ethical dimension of a situation of providing care and services (Bebeau, Rest & Yamoor, 1985). Since Rest, ethical sensitivity has been conceptualized in various ways by scholars within various professional disciplines. While all have agreed that ethical sensitivity is vital to practice, there has been no scientific consensus regarding the definition, characteristics, conditions needed for it to occur, its relation to other components of professional decision-making (such as moral agency[3]) and the outcomes and benefits for professionals, the people they serve, and society. There was need to explore and enhance the concept's comprehensiveness and utility.

Study Aims

Specific short-term. The purpose of this dissertation was to understand perspectives of professionals in providing care, treatment, and services to clients by exploring the usefulness and implications of the concept of ethical sensitivity.

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[3] Moral agency is defined as acting to implement a decision, engaging in self-determining or self-expressive ethical choice, and enacting professional responsibility and accountability through one's relationships in particular contexts (Canadian Nurses Association, 2002; Rodney & Starzomski, 1993).

Long-term. As it would enable construction of a basic foundation for ongoing and future investigation, conceptual inquiry is considered the first phase of this program of research concerning ethical sensitivity. The ultimate long-term aim of the research program is the development of a theory of ethical sensitivity for professional education and practice. This theory will enable formulation of subsequent research questions to evaluate clinical outcomes and policy implementation.

Research Questions

Research questions are formulated from substantive consideration of the topic and are generated during an iterative process of successive refinement (Miles & Huberman, 1994). The overall research question for this study was "What is the utility of the concept of ethical sensitivity to the research, theory, practice, and education of nursing and other professional disciplines?" An initial question was "How is ethical sensitivity conceptualized in the nursing and other professional literature?" As the study progressed, the initial question was modified in response to ongoing data collection and analysis to maximize exploration of ethical sensitivity according to the needs of the study. The final question was "How can the development of ethical sensitivity be enhanced in nursing and professional practice?"

Research Design

For this dissertation, a qualitative approach to concept analysis was indicated to answer the research question and to overcome the limitations apparent upon review of the relevant previous research (i.e., lack of agreement regarding the meaning of ethical sensitivity despite the completion of much investigation, scanty description of conceptual dimensions, and limited integration of the findings from disparate studies within and

across disciplines). From the literature reviewed, it was obvious professionals value ethical sensitivity. However, they may have blindly embraced the concept without knowledge of what it actually entails. Therefore, a systematic examination of the concept through exploring its application within and across various professional contexts, with the aim of developing a clearer conceptualization of ethical sensitivity, was indicated. Specifically, the most frequently used definitions, attributes (characteristics), preconditions (antecedents), boundaries (what is unique about the concept that differentiates it from others), and outcomes (consequences) of ethical sensitivity needed to be examined, compared, contrasted, and questioned. The results could then be synthesized to develop a more comprehensive concept.

This dissertation consists of a concept analysis, prepared as five manuscripts to be submitted for publication. "Paper format"[4] refers to a dissertation consisting of an introductory chapter, a body of scholarly articles either published or in the process of publication, and a final chapter discussing the conclusions of the study. Each article has been prepared according to requirements of the selected journals (specified below) and will be submitted to the journals for publication. For the purpose of this dissertation, the articles appear as chapters 1-5 with abstracts removed and a uniform format. Tables and figures are located within the text of each article rather than as an attachment preceding the references. The particular journals indicated have good to strong impact factor ratings (Web of Science) and require peer review. They have been chosen because of the fit of their mission statements and readership with manuscript purpose and scope.

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[4] A description of the paper format option is located in the University of Alberta Faculty of Graduate Studies and Research Council Regulation (1976). *Thesis Handbook: A Manual of Regulations and Guidelines for Thesis Preparation*, p. 16. Available at http://gradfile.fgsro.ualberta.ca/degreesuperv/thesis/prepare.htm

Overview of Articles

Chapter 1, "Ethical Sensitivity: State of Knowledge and Needs for Further Research" reports findings from the preliminary analysis of the professional literature which brought to light a multiplicity of terms describing ethical sensitivity and problems associated with its use that limit its utility for research and practice. This article will be submitted to *Nursing Ethics*.[5] Topics invited by *Nursing Ethics* are 'modes of thought in health care', codes of conduct, and accountability of health professionals in the areas of management, relations, client rights, and public welfare.

In Chapter 2, "The State of the Art of Concept Analysis in Nursing," the need for nursing as a professional discipline to advance its conceptual base is described and the various approaches to concept analysis for nursing are compared. This article will be submitted to *Nursing Philosophy*,[6] which focuses on phenomena of key relevance to the nursing discipline and inquiry into the means by which nursing can meet its goals.

In Chapter 3, "Inside the Morse Criterion-Based Method of Concept Analysis: Using Analytical Questions to Explore Ethical Sensitivity," the mechanics of critical appraisal are explained. This includes elucidation of the role, technique, and results of asking analytic questions that guide the synthesis of data. This article will be submitted to *Research and Theory for Nursing Practice: An International Journal*.[7] This journal invites articles discussing knowledge development and reflecting research from varied methodological approaches.

Chapter 4, "What is Ethical Sensitivity? Analysis of the Concept as Discovered in the Literature" contains the results of concept clarification. Conditions needed for ethical

[5] http://www.arnoldpublishers.com/journals/pages/nur_ethh/09697330.htm
[6] http://www.blackwellpublishing.com/journal.asp?ref=1466-7681
[7] http://www.springerpub.com/store/home_rtnp.html

sensitivity to occur, its attributes, and outcomes are described. This explication provides nurses and other professionals a comprehensive understanding of an essential aspect of professional giving of care. This article will be submitted to *Advances in Nursing Science*[8] in response to the forthcoming issue topic "Nursing Philosophy and Ethics" (June 2006). The issue will focus on works exploring lesser known perspectives. The journal itself promotes the development of nursing science, application of emerging theories and research findings, and processes of science including concept analysis and investigation of the values and ethics that influence practice and research.

Chapter 5, "Guidelines for Enhancing the Educational Development of Ethical Sensitivity," is a discussion of the adequacy of knowledge about ethical sensitivity to prepare professionals for practice and a presentation of a framework of dimension-specific clinical and classroom strategies for fostering the development of ethical sensitivity. This article will be submitted to *Milbank Quarterly*,[9] a multidisciplinary journal committed to scholarly analysis of significant issues in health and health care policy.

Method

The Morse Criterion-based method (Morse, 2000) was chosen as the method of inquiry because of its intellectual and scientific rigor. This method has the potential to advance the conceptual base of the discipline of nursing through development of pertinent concepts most relevant to its major phenomena of interest. The Morse Criterion-based method had been used to explore other concepts significant to professional practice including trust (Hupcey & Morse, 1997; Hupcey, Penrod, Morse & Mitcham, 2001). The

[8] http://ans-info.net/ANSathgd.htm
[9] http://www.blackwellpublishing.com/journal.asp?ref=0887-378X

Morse method offers clear, non-prescriptive guidance and has demonstrated capacity for cutting across disciplines, schools of thought, and subject matter to generate a holistic understanding of the concept. Although this research is focused on nursing theory and practice, disciplines do not operate in isolation of one another: ethical issues concerning health care are too complex and affect too many stakeholders for a single discipline to address. The Morse method would enable comparison between and among disciplines, thereby decreasing disciplinary bias and increasing study scope and implications. This method follows standard qualitative inquiry in that it requires concurrent data collection and analysis, ensuring validity through data adequacy, and formulating analytical questions from the data rather than applying predetermined questions. The kind of concept analysis being pursued here, using literature rather than empirical research, is descriptive in the way it focuses on behavioural patterns across various contexts. Normative work or study of how people ought to act and policies 'ought' to be implemented will come later.

Sample

Data consisted of published literature from selected professional and professional practice disciplines namely nursing, medicine, dentistry, psychology, clinical ethics, education, theology, law, business and accounting, journalism, political and social sciences, and philosophy. Inclusion criteria were accessibility, relevancy (i.e., must contain an explicit or inferred definition of ethical sensitivity), and usefulness to the emerging conceptualization. An initial sample containing 278 articles of appropriate literature was located using a multiple parameters, all fields search of on-line professional data bases (e.g., CINAHL, Medline). Further literature was recruited by seeking primary

sources of data and manual searching. Details of the sample are contained in Chapter 3, *Inside the Morse Criterion-Based Method of Concept Analysis: Using Analytical Questions to Explore Ethical Sensitivity.*

Rigor

Scientific rigor was achieved through sample adequacy, depth of analysis, intellectual rigor, development of argument, validity of results, saturation of categories, and contribution to knowledge. Rigor is fully described in Chapter 3.

Ethical Considerations

Data consisted of published literature in the public domain. As such, ethical review was not required. Throughout the study, I minimized harm to professions by reporting findings in a matter-of-fact way that did not connote acts of insensitivity as "bad" practice, but rather presented conditions in which ethical sensitivity was and was not present.

Research procedures were carried out under the supervision of Dr. Janice Morse who is recognized internationally as the expert of the method. Theories and ideas were credited to their original creator(s) and to others who significantly modified the original work. The scholarly standards for my research were additionally evaluated by an external funding agency (Atlantic Region of the Canadian Association of Schools of Nursing). Although not a part of this dissertation process, the peer review process for publication will further determine that scholarly standards have been met.

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Chapter 1

Ethical Sensitivity: State of Knowledge and Needs for Further Research

Professions are entrusted by society to provide specialized care and services that help people enhance their well-being. To ensure the safety of those receiving professional service and to assure public confidence, standards for ethical practice are developed by a profession and followed by its members (Walsh-Bowers, 1998). Professionals[1] are expected to have extensive intellectual and practical preparation and to be more strongly oriented toward community than self interest (Barber, 1988). Professionals are publicly committed to the welfare of those who seek their help (Pellegrino, 2002). Those receiving professional care and services should be able to anticipate safe, respectful, and knowledgeable treatment.

What is actually known of the quality that enables professionals to recognize and respond to the needs of those persons in their care? This quality of interpreting the ethical dimension of the care situation was introduced as *moral sensitivity* by psychologist James Rest in 1982. It was later operationalized as *ethical sensitivity* by Rest and his colleagues to delimit its scope to professional practice, reflect its linkage to professional codes of ethics, and acknowledge the inadequacy of available instruments to assess more general social values of altruism, empathy, and cynicism (Bebeau, Rest & Yamoor, 1985). Rest et al. did not 'discover" the concept of ethical sensitivity for shards of this concept have been undisputedly, albeit implicitly, present in early discourses of ethics within

[1] In this article, the term "professionals" refers to members of professional disciplines (i.e., specialized branches of knowledge, each with a unique perspective for viewing and constructing knowledge about its phenomena of interest [Donaldson & Crowley, 1997/1978]). Professionals enact socially valued occupational roles of providing specialized care and services to benefit persons in need of such care and services.

professional practice contexts. For example, buried in the Hippocratic Oath, Pellegrino and Thomasma (1993) note the percepts of respect, care, and ethical responsibility that have been shared by physicians for centuries. Through choosing, naming, defining, and attempting to measure the concept of ethical sensitivity, Rest contributed to its development and recognition of its significance to professional practice.

The purpose of this article is to identify the current state of the science about the concept of ethical sensitivity. To do this, professional literature was examined and the adequacy, clarity, and appropriateness of conceptualizations of the concept since its introduction in 1982 were explored. Content analysis of terms used in the descriptions of ethical sensitivity generated an essential multidimensional core of affect, cognition, skill, responsibility, and knowledge. Concept type (level of abstraction and scope) and maturity (usefulness of the concept to science, research, and practice) were determined. Theoretical and practical rationales for studying ethical sensitivity were discussed. The review accentuates a need for qualitative inquiry to enhance knowledge about the concept from the scientific perspectives of selected disciplines.

The Concept of Ethical Sensitivity

Ethical sensitivity is a concept, a mental representation of an object, or way of accounting for, or perceiving, reality (i.e., a word symbol) rather than the object itself (Becker, 1983; Oastler, 1978). A concept is "a stable organization in the experience of reality which is achieved through the utilization of rules of relation [e.g., seeing fresh instances of a concept] and which can be given a name" (Bolton, 1977). A particular situation or object that one has not previously encountered may be recognized as belonging to a set of objects or situations for which certain responses are appropriate

(Hunt, 1962). Concepts are shared knowledge, ways of communicating, identifying, and recognizing. They connect science and the real world as they enable data to be organized and abstracted (Morse, Mitcham, Hupcey & Tason, 1996).

Concepts differ in their level of abstraction. They are located on an "empirical-theoretical continuum" ranging from those that are empirically grounded and formed from direct observation to those that are neither directly nor indirectly observable (Jacox, 1974). While it is not difficult to understand concepts of which examples can be directly observed (Chinn & Kramer, 1999), concepts located at the farthest end of the continuum are more difficult to define. These behavioral concepts are abstract meanings which refer to complex actions, intentions, emotions, and perceptions (Morse, Hupcey, Mitcham & Lenz, 1996).

Concepts are considered as lay, scientific, or in transition between the lay and scientific realms. A lay concept is formed through human interaction, used in everyday language, understandable to people within a particular cultural context, and usually found in dictionaries. The knowledge of lay concepts is non-professional or not expert, especially with reference to law and medicine (Simpson & Weiner, 1996, p. 724). The common meaning of lay concepts may be implicit and will remain relatively stable, although the concept may be manifested differently in various contexts (Morse, 2000). Scientific concepts are developed by researchers to facilitate quantitative inquiry through identifying, labelling, and operationally defining phenomena (Morse, 2004). Scientific concepts are precisely defined to ensure consistent use (Chapman & Dixon, 1987; Pawlowski, 1980). With use and over time, concepts move from the lay to the scientific realm and vice versa. One of the primary roles of qualitative inquiry is to explicate lay

concepts for scientific use, and as scientific concepts become popularized, these concepts eventually are integrated into dictionaries and incorporated into the lay lexicon.

Background

As a scientific concept, ethical sensitivity has been explicitly defined by scholars within professional disciplines including nursing, medicine, dentistry, philosophy, business, education, psychology, bioethics, law, theology, journalism, and social and political science. Despite the volume of this work and the common definitions used, conceptual confusion prevails. There are competing conceptualizations, multiplicity of terms, semantic confusion, inadequate exploration of crucial issues, and methodological limitations. At its present level of development, comprehensive understanding of the concept is limited.

Competing Conceptualizations

Two major frameworks depict ethical sensitivity as the beginning component of professional decision-making: (a) the Rest framework (1982), developed deductively from existing theories of moral development and (b) the Lutzen framework (1993), developed inductively from qualitative studies with psychiatric nurses. Each framework portrays decision-making as a series of interrelated processes that enable professionals to recognize and interpret the ethical import of a situation. Both frameworks were developed within health care contexts. The frameworks differ in conceptualizing nature of ethical sensitivity. A third conceptualization describing ethical sensitivity from the consumer [2] perspective is included.

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[2] "Consumer" refers to a person who receives care and services by professionals and who presents her or his perspective as a user, shopper, or buyer of these care and services.

Rest framework. In the Rest (1982) framework, ethical sensitivity is the conceptualized as affect, feeling or emotion that activates cognition. It is "perception that something one might do or is doing can affect the welfare of someone else either directly or indirectly (by violating a general practice or commonly held social standard)" (Rest, 1982, p. 29). It is recognizing the ethical issue without prompting (Rest, 1994). Rest portrays ethical sensitivity as positive and mandatory for professional practice. The Rest model of decision-making is the one most frequently cited and used by researchers in the disciplines of dentistry, education, journalism, accounting, and business. Instruments based on the Rest model include the Dental Ethical Sensitivity Test (DEST) (Bebeau et al., 1985), Racial Ethical Sensitivity Test (Brabeck et al., 2000), and Test for Ethical Sensitivity in Science (Clarkeburn, 2002).

Lutzen framework. In the Lutzen framework (1993), moral sensitivity is "cognitive capacity based on intuition and feelings" (Lutzen, 1993, p. 10). This capacity includes skill in perceiving the vulnerability of clients[3] that over time develops as a stable personal characteristic (Lutzen, Johansson & Nordstrom, 2000). Dimensions of moral sensitivity are: interpersonal orientation (focus on relationship with the client), structural moral meaning (deriving meaning from decisions and actions), modifying autonomy (protecting clients from self-harm), expressing benevolence (motivation to act in the client's best interest), experiencing moral conflict (underlying feelings, intuition, and perception of a situation that compel action), and confidence in medical and nursing knowledge (Lutzen, Nordstroem & Evertzon, 1995). Lutzen developed the Moral Sensitivity Questionnaire (MSQ) to measure dimensions of feeling, intuition, benevolence, and genuineness

[3] The term "clients" refers to persons receiving care and services from professionals. The term "patients" may be used when referring to clients in health care contexts.

(Lutzen, Nordin & Brolin, 1994). Lutzen has used the MSQ within nursing and medical disciplines (Lutzen, Evertzon & Nordin, 1997; Lutzen et al., 2000; Lutzen & Nordin, 1995; Lutzen, Nordstroem et al., 1995). Other nurse researchers have used the MSQ in the context of clinical supervision (see Begat et al., 2004; Severinsson & Kamaker, 1999).

Consumer framework. The third conceptualization of ethical sensitivity from the perspective of the people using professional services rather than of the professionals themselves was constructed by researchers in business and journalism. The purpose of identifying consumer perceptions was to inform programming policy and marketing strategies. Researchers from business management (Bone & Corey, 2000; Rawwas, Patzer & Vitell, 1998) investigated shopper attitudes about altered product packaging (e.g., receiving less content in same-size packaging for the same price) and illegal activities (e.g., changing price tags on products). Researchers from journalism (Lind & Rarick, 1997, 1999; Lind, Swenson-Lepper & Rarick, 1998; Potter, 1996) studied audience ability to identify ethical issues underlying news broadcasts. "The fact that an ethically questionable line of action has been followed leads the ethically sensitive audience member to find the programming unsatisfactory, and to recognize those who produced it as culpable" (Potter, 1996, p. 9). Shifting perspectives from professionals to clients reveals a component of professional ethical sensitivity (i.e., responsibility) not as clearly addressed in the Rest and Lutzen frameworks.

Multiplicity of Terms

Contained in the above frameworks **are** the following lay terms associated with ethical sensitivity: affect, cognition, intuition, knowledge, responsibility, and skill.

Authors in each discipline have used these terms individually and in combination (see Table 1-1). Dictionary descriptors for each term were used to ensure consistency. For example, authors using "affect," "feeling," or "emotion" were classified as "affect." Intuition, although described as cognition, was retained as a separate group.

Table 1-1

Terms Associated with Major Conceptualizations of Ethical Sensitivity

Terms	Descriptors	Authors who use the term in relation to ethical sensitivity[4]
Affect	Mental state, emotion, mood, feeling, intention, desire or appetite as opposed to reason (Brown, 1973, p. 35; Simpson & Weiner, 1996, p. 24).	Bebeau, Rest & Yamoor, 1985; Callahan, 2000; Gardiner, 2003; Gastmans, 2002; Gross, 2001; Hawkins, 2001; Hepburn, 1993; Jaeger, 2001; Kitchener, 1992; Leming, 2000; Lutzen et. al., 1995, 2003; McCormack, 2003; McNamee, 2002; McPhail, 2001; Nortvedt, 2001, 2003; Nussbaum, 1985; Rest, 1982; Rosenfield & Jones, 2004; Scott, 1995; Self & Baldwin, 1990; Sherwin, 2001; Sparks & Hunt, 1998; Sparks & Merenski, 2000; Vetlesen, 1994; Welfel & Kitchener, 1992.
Cognition	Action of knowing, including perception, sensation, conception, etc. as distinguished from feeling and volition; understanding; recognition; interpretation; being aware; noticing; observing; intuition; apprehension (Brown, 1973, p. 67; Simpson & Weiner, 1996, p. 283).	Abdolmohammadi & Owhoso, 2000; Akabayashi, Slingsby, Kai, Nishimura & Yamagishi, 2004; Baldwin & Bunch, 2000; Bebeau et al., 1985; Ersoy & Goz, 2001; Ersoy & Gundogmus, 2003; Goldie, 2000; Green & Miller, 1995; Gross, 2001; Hebert et al., 1990, 1992; Hepburn, 1993; Karcher, 1996; Lutzen et. al., 1995, 1997; Meulenbergs, Verpeet, Schotsmans, & Gastmans, 2004; Narvaez, 1991; Nordgren, 1998; Owhoso, 2002; Pask, 1997; Patterson, 2001; Payne & Giacalone, 1990; Rest, 1982; Self & Baldwin, 1990; Shaner, 1989; Shaub et al., 1993; Sherwin, 2001; Smith, Dollase, & Boss, 2003; Sparks & Hunt, 1998; Sparks & Merenski, 2000; Thornton, 1999; Welfel & Kitchener, 1992; Yetmar & Eastman, 2000.

[4] Complete citations for Table 1-1 are found in Appendix A.

Table 1-1 (Continued)

Terms Associated with Major Conceptualizations of Ethical Sensitivity

Terms	Descriptors	Authors who use the term in relation to ethical sensitivity
Intuition	Instinct, insight, hunch, sixth sense, premonition, foreboding, perception, common sense, immediate apprehension by the intellect without intervention of reasoning (Brown, 1973, p. 1407; Simpson & Weiner, 1996, p. 67; Urdang, 1992, p. 244).	Aharony & Geva, 2003; Gillett, 1994; Killen, 2002; Lutzen et. al., 1995; Moll, de Oliveira-Souza & Eslinger, 2003; Nortvedt, 2001, 2003; Vetlesen, 1994; Wilson, 1993.
Knowledge	Acknowledgement or recognition of the position or claims (of anyone); legal cognizance, judicial investigation; the fact of knowing a thing or a person; the fact, state, or condition of understanding; familiarity gained by experience; intellectual acquaintance with or perception of fact or truth; information (Simpson & Weiner, 1996, p. 926). Sources of knowledge include ethical principles, theories and codes; health policy; self, academic, and clinical knowledge; own values; and values and beliefs of other decision-makers.	Coleman, 2002; Crowden, 2003; Ersoy & Goz, 2001; Ersoy & Gundogmus, 2003; Goldie, 2000; Goulston, 2001; Grandstrom, 1995; Green & Miller, 1995; Grundstein-Amado, 1992; Hillerbrand & Claiborn, 1988; Lind, 1997; Lind & Rarick, 1999; Lutzen et. al., 1994, 1995, 1997, 2003; Maier, 2000; Meulenbergs, Verpeet, Schotsmans, & Gastmans, 2004; Niven & Scott, 2003; Nortvedt, 2001, 2003; Oddi, Cassidy & Fisher, 1995; Pamental, 1989; Pask, 1997; Sherwin, 2001; Smith, Dollase, & Boss, 2003; Sparks & Hunt, 1998; Vetlesen, 1994.
Responsibility	A charge, trust, or duty for which one is responsible; morally accountable for one's actions (Simpson & Weiner, 1996, p. 1571). A principle necessitated by the power of technology; scope of responsibility extends toward the future from the need to consider the consequences of human technological powers (Mitcham, 1987).	Aharony & Geva, 2003; Bernard & Carmen, 1986; Branch, 2000; Conway, 2000; Doherty, 2001; Erwin, 2000; Glannon, 1997; Hawkins, 2001; Higgins-D'Alessandro, 2002; Intona, 2002; Lerman, 1998; Lind & Rarick, 1999; Lutzen et al., 2005; Mackay, 2004; Malone, 1997; May, 1992; Menkel-Meadow, 1991; Miller, Bersoff & Harwood, 1990; Miller, Bredemeier & Shields, 1997; Naden & Eriksson, 2004; Nesti, 2002; Nortvedt, 2001, 2003; Nussbaum, 1985; Pask, 2001; Pawlikowski, 1984; Potter, 1996; Robins, Braddock & Fryer-Edwards, 2002; Ryu, 2001; Sanders, 1992; Schnitzer, 1996; Swider, McElmurry & Yarling, 1984; Tennyson & Strom, 1986; Ulrich, Soeken & Miller, 2003; Verkerk & Njhof, 2001; Vetlesen, 1994.

Table 1-1 (Continued)

Terms Associated with Major Conceptualizations of Ethical Sensitivity

Terms	Descriptors	Authors who use the term in relation to ethical sensitivity
Skill	Talent; ability to do something acquired through practice or learning; aptitude; artistry; expertise; mastery; technique; capability of accomplishing something with precision and certainty; practical knowledge in combination with ability (Brown, 1973, p. 2883; Simpson & Weiner, 1996, p. 1782; Urdang, 1992, p. 474)	Clarkeburn, 2002; Goulston, 2001; Lutzen et. al., 1995; Niven & Scott, 2003; Nordgren, 1998; Payne & Giacalone, 1990; Sherwin, 2001; Sparks & Hunt, 1998; Sparks & Merenski, 2000; Zlotkowski, 1996.

Other terms contained in the professional literature but not explicitly conveyed in Table 1-1 as components in the major conceptualizations have been used to describe ethical sensitivity and similar concepts. These terms include: receptivity, perception, reflection, imagination, attention, intuition, sense of alarm, empathy, perspective-taking, affectivity, benevolence, compassion, collegiality, tolerance, intolerance, sympathy, caring, attitude, connectedness, comportment, behaviour, disposition, trait, courage, culpability, values, commitment, intention, law-abiding, awareness, evaluation, justification, valuing, nonMachiavellianism, altruism, transcendence, transformation, conscience, growth, whistle blowing, protection, professionalism, integrity, excellence, religiosity, prudence, competence, and wisdom (see Table 1-2). Reduction of terms was not attempted as breadth and depth in descriptions for ethical sensitivity were sought. Thus, the terms "intention" (included as a descriptor of affect in Table 1-1) and "perception" (included with cognition, intuition, and knowledge in Table 1-1) appear as separate terms in Table 1-2. Theoretical descriptors from dictionaries and other key sources helped establish the parameters of each term.

Table 1-2

Other Terms Associated with Ethical Sensitivity

Terms[5]	Descriptors	Authors who use this term in relation to ethical sensitivity[6]
Affectivity	Emotional susceptibility (Simpson & Weiner, 1996, p. 24).	Burdenski & Dunson, 1999.
Alarm	Warning of danger given in such a way as to startle or arouse the unwary, incitement, apprehension, uneasiness, alert attention (Simpson & Weiner, 1996, p. 33).	McFarland-Icke, 1999; Narvaez, 1996; Rest, 1982.
Altruism	Devotion to the welfare of others as opposed to egoism or self interest (Simpson & Weiner, 1996, p. 42).	Chin, 2001; Loye, 2002; Puxty, Sikka, & Willmott, 1994; Robins, Braddock, & Fryer-Edwards, 2002; Silverman, 1994; Steinkraus, 1987.
Attention	State of attending or giving heed, listening, watching over, ministering to, applying oneself, waiting upon; earnest direction of the mind; practical consideration, observant care; the act of attending to the comfort of others (Simpson & Weiner, 1996, p. 85-86)	Bowden, 2000; Casarett, 1999; Holland, 1991; Jenni, 1996; Lipson & Lipson, 1996; Narvaez, 1996; Niven & Scott, 2003; Pask, 2001; Scott, 2000; Walker, 1991.
Attitude	Position; stance; inclination; orientation; settled behaviour or manner of acting as representative of feeling or opinion; deliberate adoption or habitual mode of regarding the object of thought (Brown, 1973, p. 144; Simpson & Weiner, 1996, p. 24; Urdang, 1992, p. 22).	Koh, 1999; Gastmans, 2002; Lutzen & Nordin, 1993; Lutzen et al., 1995; Naden & Eriksson, 2004; Shaner, 1989.

[5] More than one descriptor term for ethical sensitivity may have been extracted from each piece of literature, Thus the same author(s) may appear with different descriptors.

[6] Complete citations for Table 1-2 are found in Appendix B.

Table 1-2 (Continued)

Other Terms Associated with Ethical Sensitivity

Terms	Descriptors	Authors who use this term in relation to ethical sensitivity
Awareness	The quality or state of being aware: informed, in the know, cognizant, conscious, vigilant, cautious, on one's guard (Brown, 1973, p. 157-158; Simpson & Weiner, 1996, p. 93; Urdang, 1992, p. 24).	Batson et al., 1999; Bebeau et al., 1985; Bone & Corey, 2000; Canon, 1992; Cranston, 1995; Duckett & Ryden, 1994; Erwin, 2000; Everett & Piercy, 1997; Gius & Coin, 2000; Kreuter, Parsons, & McMurry, 1982; Kuhse, 1995; Lind & Rarick, 1995; Lind & Sevenson-Lepper, 1998; Lutzen et al., 1994, 1997, 2003; May, 1992; Penticuff & Walden, 2000; Rabins, 1998; Rest, 1994; Shaner, 1989; Steinkraus, 1987; Welfel, 1992; Winstanley & Woodall, 2000.
Behaviour	Manner of conducting oneself in the external relations of life; demeanor; deportment; bearing; course of action toward or to others; treatment of others (Simpson & Weiner, 1996, p. 122).	Armstrong, Ketz & Owsen, 2002; Chen, Sawyers, & Williams, 1997; Furberg, 1999; Gius & Coin, 2000; Hall, 1987; Housman & Stake, 1999; Narvaez, 1991; Pamental, 1989; Scott, 1995; Smith, Skalnik & Skalnik, 1999.
Benevolence	Disposition to do good; desire to promote the happiness of others; kindness, generosity, charitable feeling (Simpson & Weiner, 1996, p. 126)	Begat, Berggren, Ellefsen & Severinsson, 2003; Begat, Ikeda, Ameniya, Eriko, Inasala & Severinsson, 2004; Lutzen, 1993; Mudrack, Mason & Stepanski, 1999; Severinsson & Kamaker, 1999.
Caring	The action of the verb: to care; compassionate; concerned (Simpson & Weiner, 1996, p. 214). Caring in nursing identified as: human trait, moral imperative or ideal, affect, interpersonal relationship, and therapeutic intervention (Morse, Solberg, Neander, Bottorff & Johnson, 1990, p. 3).	Benner & Wrubel, 2001; Branch, 2000; Flannery, 1995; Gastmans, 2002; Grundstein-Amado, 1992; Huebner, 1996; Kuhse, 1995; Tarlier, 2004; Scott, 2000; Watson & Smith, 2002.

Table 1-2 (Continued)

Other Terms Associated with Ethical Sensitivity

Terms	Descriptors	Authors who use this term in relation to ethical sensitivity
Choice	The act of choosing; preferential determination between things; that which is specially chosen or to be chosen on account of its excellence; the person or thing chosen or selected; judgment; discrimination (Simpson & Weiner, 1996, p. 250).	Steinkraus, 1987; Jaeger, 2001.
Collegiality	Relational; sharing (Simpson & Weiner, 1996, p. 287). The literature refers to egalitarianism and participatory relationship. "Power distance" is the influence between supervisor and subordinates (Hofstede, 1983).	Cannon, 1985; Matsumoto, Haan, Yabrove, Theodorou, & Carney, 1986; Miller, Bredemeier, & Shields, 1997; Sarat, 1991
Commitment	Action of entrusting; an engagement; a liability; an obligation; an absolute choice of a moral action (Simpson & Weiner, 1996, p. 296).	Grant, 2002; McFall, 1987; Robins et al., 2002; Schneyer, 1991.
Compassion	To suffer together; feeling of emotion when person is moved by the suffering and distress of another and by the desire to relieve it (Simpson & Weiner, 1996, p. 300).	Arvidson, 2003; Bracci, 2001; Pask, 2001; Piper, 1991; Scott, 1995; Tarlier, 2004.
Competence	Aptness, finesse, agreeableness; sufficiency of qualification; capacity to deal adequately with a subject (Simpson & Weiner, 1996, p. 300)	Scanish, & McMinn, 1996.
Connectedness (to others, to God)	The state or quality of being connected or coherence (Simpson & Weiner, 1996, p. 316).	Bouley, 1984; Mackay, 2004; Pawlikowski, 1984; Scanish & McMinn, 1996.
Comportment	Demeanour, deportment, conduct of oneself or one's body (Simpson & Weiner, 1996, p. 302)	Benner, 1991; Benner & Wrubel, 2001

Table 1-2 (Continued)

Other Terms Associated with Ethical Sensitivity

Terms	Descriptors	Authors who use this term in relation to ethical sensitivity
Conscience	Inward knowledge; partial recognition or acknowledgment of something; internal conviction; sense of right or wrong as regards things for which one is responsible; the faculty or principles which pronounces upon the moral quality of one's actions or motives, approving the right and condemning the wrong (Simpson & Weiner, 1996, p. 317).	Callahan, 2002; Issler, 1993; Pawlikowski, 1984; Stilwell, Galvin, Kopta & Padgett, 1998.
Courage	What is in one's heart, mind, and thoughts; intention; spirit, vital force, energy; quality of mind that shows itself in facing danger without fear or shrinking; acting consistently with one's opinions (Simpson & Weiner, 1996, p. 350).	Callahan, 2002; Mohr & Horton-Deutsch, 2001; Naden & Eriksson, 2004; Stark, 2001.
Culpability	Quality of being guilty, criminal, or deserving punishment or condemnation; blameworthy; liable (Brown, 1973, p. 568; Simpson & Weiner, 1996, p. 374).	May, 1992; McPhail, 2001; Potter, 1996.
Disposition	Aptitude or capacity for accomplishing a purpose; bestowal by deed or will; natural tendency or bent of the mind, especially in relation to moral or social qualities; (Simpson & Weiner, 1996, p. 452).	Gustafson, 1982; Johnson, 2001; Keep, 2003.
Empathy	Power of projecting one's personality into (and so fully comprehending) the object of contemplation (Simpson & Weiner, 1996, p. 508). Emotional empathy: "arousal or responsiveness component resulting in empathic insight" (Morse, Miles, Clark & Doberneck, 1994, p. 235). Compathy or physical empathy: "the physical response or arousal that is evoked in an individual by observing or comprehending the physical distress of another" (Morse & Mitcham, 1997, p. 650).	Brabeck et al., 2000; Everett & Piercy, 1997; Higgins-D'Alessandron, 2002; Killen, 2002; Malone, 2000; Rest, 1982; Reynolds, Scott & Austin, 2000; Sieminska et al., 2002; Sloan, 2003; Vasquez, 1992.

Table 1-2 (Continued)

Other Terms Associated with Ethical Sensitivity

Terms	Descriptors	Authors who use this term in relation to ethical sensitivity
Evaluation (of the morality of a particular action or issue)	The action of appraising or valuing (goods, etc.); a calculation or statement of value (Simpson & Weiner, 1996, p. 536)	Cohen, Pant & Sharp, 1996; Conway, 2000; Kimmel, 1991; Lind & Rarick, 1999; Lind, Rarick & Swenson-Lepper, 1997; Mancuso et al., 1978; Patterson, 2001; Shaub, Finn & Munter, 1993; Simga-Mugan & Onkal-Atay, 2003.
Excellence	Possessing good qualities in an eminent degree; surpassing merit, skill, virtue (Simpson & Weiner, 1996, p. 543). Responding "at the right times, with reference to the right objects, towards the right people, with the right aim, and in the right way, is what is appropriate and best, and this is characteristic of excellence" (Aristotle, 1962, 1106b21-3).	Robins, Braddock & Fryer-Edwards, 2002.
Growth	Action, process, or manner of growing (Simpson & Weiner, 1996, p. 714).	Higgins-D'Alessandro, 2002.
Imagination	Forming a mental concept of what is not actually present to the senses; the mental consideration of actions or events not yet in existence; creative faculty of the mind and power of framing new conceptions (Simpson & Weiner, 1996, p. 816).	Churchland, 1996; Ciulla, 1998; Clarkeburn, 2002; Goulston, 2001; Huebner, 1996; Nordgren, 1998; Nussbaum, 1985; Pamental, 1989; Pask, 1997, 2001; Piper, 1991; Rest, 1986; Schnitzer, 1996; Scott, 2000; Scully, 2003.
Integrity	Wholeness, completeness, entirety, purity, freedom from corruption; uprightness, honesty, sincerity (Simpson & Weiner, 1996, p. 860)	Al-Kazemi & Zajac, 1999; Bailey, 1999; Batson, Thompson, Seuferling, Whitney & Strongman, 1999; Hardingham, 2004; Huebner, 1996; Iruta & Williams, 2001; Simon, 1991; Tarlier, 2004.
Intention	Act of directing the mind or attention to something; mental application or effort; faculty of understanding; meaning; significance; purpose; volition which one is minded to carry out (Simpson & Weiner, 1996, p. 862).	Loye, 1993; Smilansky, 1996.

Table 1-2 (Continued)

Other Terms Associated with Ethical Sensitivity

Terms	Descriptors	Authors who use this term in relation to ethical sensitivity
Intolerance of unethical conduct	Quality of not tolerating or enduring (something); inability or unwillingness to tolerate or endure (Simpson & Weiner, 1996, p. 870)	Ameen, Guffey & McMillan, 1996; Coleman & Mahaffey, 2000; Fleming, 1995; Keep, 2003; Kitchener, 1992; Sirin, Brabeck, Satiani & Rogers-Serin, 2003; Teoh, Serang & Lim, 1999.
Justification	Quality of being justifiable; capable of being legally or morally justified, or shown to be just, right, or innocent; defensible (Simpson & Weiner, 1996, p. 905).	Grundstein-Amado, 1992; Miller, 2002; Norman, 2001; Pamental, 1989; Raywid, 1986.
Law-abiding	Maintaining or submitting to the law (Simpson & Weiner, 1996, p. 948)	Arab, 2001; Steppe, 1992
Non-Machiavellian	Not Machiavellian; not preferring expediency to morality; not cunning (Simpson & Weiner, 1996, p. 1013).	Pinto & Kanekar, 1990; Rawwas et al., 1998; Sparks & Merenski, 2000
Perception	Receiving, apprehending; being aware of objects in general; being affected by an object without contact; intuition or direct recognition of a moral or aesthetic quality. Different from sensation, conception, or imagination (Simpson & Weiner, 1996, p. 1307).	Al-Kazemi & Zajac, 1999; Blum, 1991; Bone & Corey, 2000; DesAutels, 1996; Furberg, 1999; Gastmans, 2002; Gillet, 1994; Holland, 1998; Kane, 2003; Keenan, 2002a, 2002b; Mancuso, Morrison & Aldrich, 1978; Marta, Attia, Sighapakdi & Atteya, 2003; Narvaez, 1996; Scott, 2000; Teoh, Serang, & Lim, 1999; Ulrich, Soeker & Miller, 2003.
Perspective taking	Seeing into a thing, insight, mental view, outlook, taking a particular point of view (Simpson & Weiner, 1996, p. 1316-1317)	Baron, 1991; Blodgett et al., 2001; Brabeck et al., 2000; Everett & Piercy, 1997; Hawkins, 2001; Jaeger, 2001; Pratt & Norris, 1999; Scully, 2003; Sparks & Hunt, 1998.
Professionalism	Quality, character, method, or conduct; the position or practice of a professional as distinguished from an amateur (Simpson & Weiner, 1996, p. 1440).	Baldwin & Bunch, 2000; Chin, 2001; Stohr, Hemmens, Kifer & Schoeler, 2000.

Table 1-2 (Continued)

Other Terms Associated with Ethical Sensitivity

Terms	Descriptors	Authors who use this term in relation to ethical sensitivity
Protection (of rights – privacy, autonomy)	Defend or guard from injury or danger; shield; to keep safe (Simpson & Weiner, 1996, p. 1451).	Banja & Banes, 1993; Fule & Roddick, 2004; Jeffer, 2002; Schroeter, 1999.
Prudence	Foresight, sagacity, ability to discern the most suitable course of action; wisdom, knowledge of or skill in a matter (Simpson & Weiner, 1996, p. 1457)	Nortvedt, 1998
Receptivity	Ability or readiness to receive or take in (Simpson & Weiner, 1996, p. 1525)	Bowden, 2000; Branch, 2000; Fricker, 2003; Gastmans, 2002; Kuhse, 1995.
Reflection	Act of turning (back) or fixing the thoughts on some subject; faculty by which the mind has knowledge of itself and its operations by which it deals with the ideas received from sensation and perception; thinking about something after the event (Findlay & Gough, 2003, p. xxx; Simpson & Weiner, 1996, p. 1541).	Baron, 1991; Casarett, 1999; Fricker, 2003; Green & Miller, 1995; Keekes, 1984; Momeyer, 2002; Pask, 2001; Tirri, 1999; Self & Baldwin, 1990.
Religiosity	Religious feeling or sentiment; excessive religiousness (Simpson & Weiner, 1996, p. 1552)	Conroy & Emerson, 2004; Stander, Piercy, MacKinnon & Helmeke, 1994.
Sympathy	Conformity of feelings, inclinations or temperament; the quality or state of being affected by the condition of another with a feeling similar or corresponding to that of the other; feeling of compassion or commiseration (Simpson & Weiner, 1996, p. 1991)	Smilanski, 1996.
Tolerance (of others, of uncertainty and ambiguity)	Disposition to be patient with or indulgent to the opinions or practices of others; freedom from undue severity in judging the conduct of others; forbearance (Simpson & Weiner, 1996, p. 2075)	Botes, 1999; Botes & Otto, 2003; Brabeck et al., 2000; Connolly, 1993; Jaeger, 2001; Norman, 2000; Rudin, Edelson & Servis, 1998; Rossouw, D. 1994; Rossouw, J. 1994.
Trait	A particular feature of mind or character; a distinguishing quality; a characteristic (Simpson & Weiner, 1996, p. 2094).	Crowden, 2003, 2004; Lowe, Kerridge, Bore, Munro, & Powis, 2001; Scott, 1995.

Table 1-2 (Continued)

Other Terms Associated with Ethical Sensitivity

Terms	Descriptors	Authors who use this term in relation to ethical sensitivity
Transcendence	Action of surmounting, rising above, excelling, surpassing (Simpson & Weiner, 1996, p. 2096). Percepts of transcendence: intelligent, reasonable, responsible, and love (Lonergan, 1972).	Bouley, 1984; Cottingham, 1991; Hansen & Hall, 1997; Pawlikowski, 1984; Procario-Foley & McLaughlin, 2003.
Values	A thing regarded as worth having; worth or worthiness (of persons) in respect of rank or personal qualities (Simpson & Weiner, 1996, p. 2212).	Arant & Meyer, 1998; Bahcecik & Ozturk, 2003; Diegmueller, 1994; Kumar, 1995; Lutzen, 1990; Myyry & Helkama, 2002; Penticuff & Walden, 2000.
Valuing	The worth or importance (Simpson & Weiner, 1996, p. 2212).	Bracci, 2001; Patterson, 2001; Rawwas et al., 1998; Schroeter, 1999; Sparks & Hunt, 1998; Wittmer, 1992, 2000.
Whistle blowing	To bring an activity to a sharp conclusion by informing on (a person) or exposing (an irregularity or crime) (Simpson & Weiner, 1996, p. 2307) .	Cherrington, 2002; Grant, 2002; Keenan, 2002; Rennie & Crosby, 2002.
Wisdom	Capacity of judging rightly in matters relating to life and conduct; sound judgement in choice of means and ends; a gift constituted by "illumination of the intellect together with charity inflaming the heart" (Simpson & Weiner, 1996, p. 2325).	Crowden, 2003, 2004; Fowers, 2003; Simpson & Garrison, 1995.

To reduce confusion from the diversity of the terms, descriptors for each term in Tables 1-1 and 1-2 were compared with each other and with theoretical definitions to identify their basic components. Some terms corresponded to more than one component; for instance, intuition has both cognitive and affective components. Wisdom has every component. All of the terms roughly fit within a core domain comprised of affective, cognitive, skill, knowledge, and responsibility components (see Figure 1-1).

Characteristics	Combined Core				
	Cognitive	Affective	Skill	Responsibility	Knowledge
Perception	X				
Receptivity	X				
Reflection	X				
Attention	X				
Intuition	X	X			
Sense of Alarm		X			
Emotional Empathy		X			
Perspective Taking		X			
Physical empathy/Compathy		X			
Affectivity		X			
Religiosity/Connectedness		X			
Non-Machiavellian		X			
Compassion/ Sympathy		X			
Collegiality/ Altruism		X			
Tolerance/Intolerance		X			
Benevolence		X	X		
Caring		X	X		
Comportment/Behaviour			X		
Attitude			X		
Disposition/Trait			X		
Imagination			X		
Courage		X	X	X	
Commitment		X	X	X	
Choice		X	X	X	
Law-abiding			X	X	
Awareness/Effects/Actions	X			X	
Integrity/Protection		X		X	
Intention				X	
Culpability				X	
Whistle blowing			X	X	
Professionalism/Competence			X	X	X
Evaluation			X		X
Justification			X		X
Valuing		X	X		X
Values		X			X
Transformation		X			X
Conscience		X			X
Sources of Knowledge					X
Ethical Principles/Theories					X
Ethical Codes					X
Health Policy					X
Self Knowledge					X
Clinical Knowledge					X
Growth	X	X	X	X	X
Transcendence	X	X	X	X	X
Wisdom	X	X	X	X	X
Prudence	X	X	X	X	X
Excellence	X	X	X	X	X

Figure 1-1. Characteristics of the combined core of the concept of ethical sensitivity.

The identification of a core domain with linkages between its components suggests that the terms describe a single phenomenon rather than several different phenomena. This is, to some extent, supported by two previous efforts to clarify and consolidate knowledge of ethical sensitivity. May (1992), through philosophical inquiry, identified the following attributes: (a) perceiving or attending, (b) caring about the impact of one's actions, and (c) appreciating the diversity of and the legitimacy of the needs and feelings of those affected by one's conduct. Sparks and Hunt (1998) sorted definitions of ethical sensitivity from psychology, dentistry, and accounting disciplines into two constructions: (a) recognizing an issue as ethical and (b) ascribing value to the issue. Correlation using confirmatory factor analysis and coefficient alpha identified ethical sensitivity as both recognition and ascription.

Semantic Confusion

Ethical sensitivity is used interchangeably with the following scientific concepts: moral sensitivity, clinical sensitivity, moral perception, ethical perception, clinical perception, ethical intuition (e.g., see Nortvedt, 2001), and moral or ethical sensibility (e.g., Fowers, 2003; Fricker, 2003). These concepts are used by authors to convey the professional's role and responsibility to clients, arising from affective, intuitive, and cognitive responses, and from identification and application of academic or technical knowledge. Nortvedt's discourse (1993; 1998; 2001; 2003) is particularly rich in describing professional ability and responsibility concerning morally relevant features of professional - client interactions. It is difficult, however, to come to terms with exactly what is entailed because these concepts are not explicitly defined.

To differentiate between moral perception, moral sensitivity, clinical perception, clinical sensitivity, ethical or moral sensibility, ethical intuition, and ethical sensitivity; (a) moral, ethical, and clinical and (b) sensitivity, sensibility, intuition, and perception were compared in terms of scope and focus.

Moral, ethical, and clinical. Moral is derived from the Latin term "moralis" (Simpson & Weiner, 1996, p. 1114) and ethical from the Latin "ethicus" and Greek "ethikos" (Simpson & Weiner, 1996, p. 534) which all pertain to character, habits, and manners. These shared etymological roots lend support to assertions by some contemporary authors in nursing and medical ethics (e.g., Glannon, 2005; Storch, 2004) that the terms ethical and moral may be used interchangeably in practice. Yet, other authors in medical, nursing, bioethics, education, and business ethics have identified significant conceptual differences between ethical and moral. The first difference is that *ethical* involves "disciplined reflection" (Veatch, 1997, p. 1), a standing back from everyday practices and their embedded values to reflect on underlying principles, decisions, and problems (Petrick & Quinn, 1997), "understanding and examining the moral life" (Beauchamp & Childress, 2001, p. 1). This sense of systematic reflection is not conveyed in the use of the term *moral* which refers to the norms about right and wrong conduct (Beauchamp & Childress, 2001) and to acting according to this set of norms which were developed from religious and social values governing collective and individual behaviour (Fontes & Piercy, 2000; Tabordą & Arboleda-Florez, 1999).

The second difference is that ethical and moral may be, in some instances, diametrically opposed (Petrick & Quinn, 1997). To illustrate, Petrick and Quinn refer to the historical American customary sociolegal practice of maiming recaptured fugitive

slaves. Although this practice was morally condoned before the American Civil War, ethically sensitive managers critiqued, challenged, and objected. Thus, ethics may provide "needed correction to the entirety of mortality's norms" (Taborda & Arboleda-Florez, 1999, p. 189).

A third difference between ethical and moral concerns the relation between them. Ethics is a branch of philosophy that investigates its field of study and object: morality (Taborda & Arboleda-Florez, 1999). As such, ethics and morality are not the same. Fourthly, ethical differs from moral in that ethical is drawing on principles or general patterns of behaviour to judge the goodness or rightness of human decisions and conduct by their conformity to values and codes established by professional organizations (Anderson & Davies, 2000; Fowler & Fry, 1988). Morality has a broader meaning as it extends "beyond the rules in professional codes of conduct adopted by organizations and professional associations" (Beauchamp & Bowie, 1997, p. 1).

From the above examples, there seems to be agreement that ethics or ethical is different from morality. However, there is no consensus that ethical is different from moral. Jonsen (2000, p. x) finds this confusing and asks: Do ethics or morals refer to the actual behaviour of professionals in practice, the rules professionals ought to follow in interacting with clients and colleagues, or the deeper principles and theoretical frameworks that should guide professionals and indeed all persons? The overlap and the confusing use of ethical and moral may impair disciplinary communication and knowledge construction. The confusion will continue if disciplines do not assign priority to clarifying the issue. Lutzen (1993) used the label moral after differentiating between ethical (i.e., concern with universals such as justice [although criteria for what is just vary

among societies]) and moral (i.e., concern with the concrete level of social conventions such as beliefs about what is "right" or "good" embodied in daily life and subject to change with history and culture). The task of stringently comparing the various representations begun by Lutzen must continue to ensure accuracy in concept use and knowledge development.

The etymological root of *clinical* means treating a subject matter as if it were a disease, that is, being technical or "coldly detached and dispassionate" (Simpson & Weiner, 1996, p. 270). Clinical pertains to decisions in the practice setting that may or may not have an ethical dimension. In addition to other things, including the character and values of the professional and the relationship between the professional and client, "a given situation has ethical content when an action, freely performed, has the potential to harm or benefit others" (Bone & Corey, 2000, p. 201). Therefore, a decision is strictly clinical (i.e., technical or business) if it does not involve a decision regarding potential harm or benefit to those affected.

Sensitivity, sensibility, intuition, and perception. Sensitivity, sensibility, intuition, and perception may be differentiated by scope and focus. *Perception* is taking in or receiving, a function of cognition (Simpson & Weiner, 1996, p. 1307). *Intuition* is looking upon or into; it is generally described as immediate apprehension of an object by sense without the intervention of any reasoning process (Simpson & Weiner, 1996, p. 872). The difference between perception and intuition is that perception may involve apprehension through reasoning, and intuition through sensing. Sensitivity and sensibility have broader scope than perception and intuition for sensitivity and sensibility are both derived from the Medieval Latin verb "sentire" (Simpson & Weiner, 1996, p. 1711)

which means to perceive and to feel, a function which encompasses cognition and affect. *Sensitivity* is the quality of making even the minutest phenomenon appear important to one's attention (Simpson & Weiner, 1996). It contains an element of developing and adjusting the self through experience and critical reflection (Fricker, 2003; Keekes, 1984). Without such sensitivity, one might perceive an ethical issue yet assign little importance to it (Wittmer, 1992). *Sensibility* is the capacity to feel and be moved by others (Simpson & Weiner, 1996, p. 1711). Sensitivity has a more inclusive focus than sensibility, intuition, and perception as sensitivity includes awareness of the motives and feelings of self as well as those of others external to self.

Ethical sensitivity, *moral sensitivity*, *ethical perception*, *clinical perception*, *clinical sensitivity*, *ethical intuition*, and *moral* or *ethical sensibility* are allied concepts. They share some attributes but do not necessarily represent the same phenomena. In the interest of knowledge development within and between disciplines, the distinctions between these allied concepts must be considered in research and practice.

Inadequate Exploration of Critical Issues

Perusal of the literature revealed areas about ethical sensitivity that have been inadequately explored: negative consequences, the role of education, and nature.

Negative consequences. There is a bias toward uncritical acceptance of ethical sensitivity as a desirable quality for professional practice without a corresponding examination of its negative consequences. Emotional overload (e.g., becoming too affected by the import of a situation to function), exploitation (e.g. by those who exaggerate their situations to extract goods or services), personal loss (e.g., being fired because of blowing the whistle on unethical organizational practices), and moral distress

(e.g., from participating in care situations which compromise personal or professional integrity) are associated with high levels of ethical sensitivity (Cherrington, 2002; Corley, 1995; Erlen, 2001; Fenton, 1988; Grant, 2002; Smilansky, 1996). These consequences warrant further investigation as they influence a professional's behaviour in a given situation and may negatively impact on professions.

Role of education. The role of education in developing ethical sensitivity is unclear. Findings do not consistently support the benefit of educational strategies. For example, clinical exposure is regarded as the "best" way to help students develop ethical sensitivity. Yet, ethical sensitivity scores of medical students increase during the first year of clinical practice but decrease thereafter (Akabayashi, Slingsby, Kai, Nishimura & Yamagishi, 2004; Bissonette, O'Shea, Horwitz & Route, 1995; Hebert, Meslin & Dunn, 1992; Patenaude, Niyonsenga & Fafard, 2003). Two of the most common modes for teaching ethical sensitivity in professional schools (i.e., vignette and case study method) do not reliably demonstrate effectiveness. They have been criticized for conveying ethics as problem solving (McPhail, 2001), artificially constructing a task based on post hoc moral justification (Lowe, Kerridge, Bore, Munro & Powis, 2001), starting "too far down the road" by presenting explicitly formed cases (Punzo, 1996, para 23), and distorting the socialization process of students who are learning to alter their perceptions of what is going on around them (Goldie, 2000). Other teaching methods including the use of film and literature (e.g., Goulston, 2001; Green & Miller, 1995; Macnaughton, 2000) have not been scientifically evaluated. Pettifor, Estay, and Paquet (2002) found a variety of methods more helpful to adult learners than a single approach. This may relate to different strategies fostering different components of the multidimensional core of ethical

sensitivity. Further clarification of the concept may enable enhanced fit and design of teaching strategies.

Nature. Two issues about the nature of ethical sensitivity have been inadequately addressed: (a) Is it innate or acquired? (b) What is the relationship between ethical sensitivity and agency[7] The identification of an affective component (e.g., compassion and empathy) within its core suggests the presence of an innate, universal human characteristic as Nortvedt (1998), Silverman (1994), and Vetlesen (1994) have argued. The identification of skill, responsibility, and knowledge components conveys ethical sensitivity as acquired behaviour that is situation-specific (Blum, 1991; Kuhse, 1995; Steinkraus, 1987). Further analysis is needed to determine if ethical sensitivity is both innate and acquired.

Although accounting and business scientists have found no correlation between ethical sensitivity and agency (Al-Kazemi & Zajac, 1999; Sparks & Merenski, 2000), certain philosophers and theologians have linked ethical sensitivity with agency (e.g., Furberg, 1999; Johnson, 2001; Narvaez, 1991). Variation in defining ethical sensitivity across these inquiries hinders explication of its relationship to agency.

Methodological Difficulties

Methodological difficulties may have compromised rigour in many of the published qualitative and qualitative studies. These difficulties will be discussed in terms of generalizability and validity issues which limit integration and usefulness of findings.

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[7] Moral agency is defined as acting to implement a decision, engaging in self-determining or self-expressive ethical choice, and enacting professional responsibility and accountability through one's relationships in particular contexts (Canadian Nurses Association, 2002; Rodney & Starzomski, 1993).

Generalizability issues. Generalizability enables findings from the sample or situation studied to be extended to the larger population or larger situation (Morse, 1999). In quantitative inquiry, findings can be generalized to the population if the sample accurately represents the population. Generalizability in most of the quantitative studies was compromised by not ensuring that the sample matched the population (e.g., convenience rather than randomly selected samples). Generalizability in qualitative research depends on the degree of abstraction and the comprehensiveness of the results which allow for findings to be applied to other settings (Horsburgh, 2003; Morse, 1999). In some studies, generalizability was compromised by thin, under-developed theory.

Validity issues. Validity requires that study results accurately reflect reality (Morse & Richards, 2002). Validity in the quantitative studies was decreased in the following ways: recruitment of only students as study participants, cuing of participants to the presence of an ethical problem, failure to ensure accurate conclusions about relationships studied, and limitations in underlying theoretical frameworks and definitions used. Studying professional ethical sensitivity by sampling only students is inappropriate, according to Sparks and Merenski (2000), because students do not have first hand experience. This problem could be particularly difficult if recruiting first year students who have not had opportunity to develop the skill and knowledge components of ethical sensitivity through practice and study. Cuing participants to the presence of an ethical problem reduces rigour (Welfel & Kitchener, 1992; Wittmer, 2000). It cannot be assumed individuals would recognize an issue as ethical if not instructed in advance; therefore, under this condition, the measurement is threatened. Statistical conclusions may have been threatened by not consistently reporting power, instrument parametrics,

and response rates. Standard distributions with which to compare raw scores were not consistently used in interpreting ethical sensitivity results.[8] In addition, the adequacy of the theory underlying a study or a measurement instrument was frequently not articulated. The Rest framework (1982) underlying the DEST does not include institutional and environmental factors (Canon, 1992). The DEST does not assess beliefs important to the ethical issue in the drama (Sparks & Hunt, 1998).

Validity in the qualitative studies was assessed through authors' descriptions of purposive sampling, saturation, negative cases, and the kind of analytic questions the researchers asked themselves and the data. Validity of all of the qualitative research was to some extent preserved because participants were asked to describe their own experience of making decisions when working with vulnerable clients, data were examined for themes, and findings were fit into extant literature. For example, Lutzen (1990) implemented an iterative process of data collection and analysis in defining the concept as nurse awareness of and responsibility toward responding to client needs as well as the process by which the nurse critically examines the care situation (Lutzen, da Silva & Nordin, 1995). Nortvedt (1993; 1998; 2001; 2003), through indepth questioning and challenging of obvious and covert assumptions, illuminated the affective, skill based, responsibility, cognitive, and knowledge aspects of ethical sensitivity.

Inability to integrate findings. The use of different conceptualizations and measures for ethical sensitivity has made it difficult to integrate findings. For example, nursing researchers have defined and measured ethical sensitivity in at least three

[8] An exception is the establishment of criterion-based scoring for the DEST instrument and norms for the population of dental students at Minnesota University (e.g., Bebeau & Brabeck, 1994; Bebeau & Brabeck, 1987, 1989; Bebeau et al., 1985) which has enabled accurate interpretation of scores.

differing ways: (a) as identification of the number of ethical issues (Ersoy & Goz, 2001), (b) as recognition of the significance of ethical issues as shown by describing the unique characteristics of situations and persons receiving care (Duckett & Ryan, 1994), and (c) as attitudes to issues such as the use of restraints and forced medication administration (Lutzen et al., 1994). The use of different conceptualizations for ethical sensitivity is also apparent across disciplines. Shaub and colleagues (1993) of accounting measured the number of issues participants identified while Myyry and Helkama (2002) of social psychology measured participant evaluation of the magnitude of the ethical issues regardless of participant ability to identify the issues as ethical. Until there is agreement about the definition of ethical sensitivity, findings from individual studies cannot be consolidated and further research will not significantly contribute to disciplinary knowledge development.

Assessment of Ethical Sensitivity as an Emerging Concept

The professional literature about ethical sensitivity reveals a clutter of descriptors, lack of conceptual clarity and consolidation, and difficulty with generalizability and integration of findings. This indicates ethical sensitivity is an *emerging* scientific concept. It is in the process of maturing and of being used in scientific literature, in practice, and in research settings. Emerging scientific concepts may lack explication of consensus about their meaning and use, and because of their newness, they may be relatively ignored, used in a perfunctory manner, or used in a different manner than the developer's intent (Morse, personal communication, January 24, 2005).

Evolution. An emerging concept represents empirical reality (or an aspect of that reality) which is meaningful to scientists and persons within a circumscribed domain.

Prior to emergence, the concept may have been implicit in science and society. Through emergence, the concept is explicated for use in research and theoretical constructions. According to Kuhn (1970, p. 17), during the early stages of scientific inquiry, different researchers confronting the same phenomenon may describe and interpret it in different ways. Proliferation of the same concept with different names may occur if an emerging concept duplicates concept labels already in use. Similarly, proliferation of various descriptors without consolidation into a whole may contribute to chaos or clutter, and stall advancement of the science of a discipline.

Type. Concept type is based on scope and level of abstraction (Morse, 2004). Concepts range from low level (i.e., have local, narrow scope with limited application and generalizability) to high level (i.e., may encompass several lower level concepts and have broad application). They may be horizontal (i.e., have dominant position with respect to the other concepts they encompass) or they may be paradigmatic (i.e., deductively applied to clustered concepts or developing theory). Ethical sensitivity is classified as a low level concept because it refers to a particular set of behaviours associated with professional practice.

Maturity. Concept maturity is based on the level of agreement of a concept's meaning and structure, and the consistency of its use. Concepts range in maturity from immature to mature. Immature concepts may have multiple or ambiguous definitions, be used inconsistently in practice and research, and their structure may not be sufficiently clarified for them to be theoretically combined with other concepts (Morse, Mitcham et al., 1996). Concepts are mature once they are unambiguously defined in scientific literature and there is agreement about their attributes (characteristics), which are clearly

described (Morse, Hupcey et al., 1996). Mature concepts hold their boundaries in combination with others in theory (Morse, Hupcey, Penrod & Mitcham, 2002). They may or may not be used consistently in various practice and research contexts (Hupcey & Morse, 1995). The concept of ethical sensitivity falls between immature and mature and is considered *partially mature.* Because an adequate body of professional literature about ethical sensitivity is available, this partially mature concept may be developed to a higher level of maturity through exploring its applications within and across various contexts and by synthesizing this information.

Theoretical and Practical Significance of the Concept of Ethical Sensitivity

Ethical sensitivity has emerged as a scientific concept within the past 20 years. Its contribution to professional decision-making, however, has been longstanding. Explicating this contribution through conceptual inquiry may help professionals better understand their role and responsibilities toward clients. The findings may assist professionals to evaluate the usefulness of the concept to their everyday work with clients and organizations. It is taken for granted professionals will apply ethical sensitivity in their practice. It is a matter of utmost concern when they do not.

Greater knowledge about ethical sensitivity may aid understanding of the professional perspective when care and treatment potentially jeopardize the comfort and integrity of those receiving it. It may help professionals interpret research findings that indicate violation of standards for ethical practice in health care treatment (e.g., Fitch, Greenburg, Cava, Spaner & Taylor, 1998; Koch, Webb & Williams, 1995; Weaver, 2001). When clients do not feel their particular perspectives are considered, their participation in and satisfaction with care and services may be lessened (Brown, 1986;

Lutzen & da Silva, 1996). They may experience treatment as institutional or professional focused rather than person-centered, and they may subsequently perceive care and services as traumatic (Sarat, 1991).

Research about ethical sensitivity can inform the design of person-centered care and services and professional educational programs. Professional disciplines can profit individually from the research because it can help to develop knowledge needed for practice. These disciplines can benefit collectively because the research can help to enhance interdisciplinary understanding and communication.

Conclusion

The state of the science about ethical sensitivity is reflected in this baseline assessment. Ethical sensitivity is a scientific concept representing an aspect of decision-making in professional practice. As an emerging concept, it lacks comprehensiveness and clarity. Neither scientific nor philosophical communities have reached consensus regarding defining characteristics, conditions needed for ethical sensitivity to occur, and its outcomes for professionals, clients, and society. Individual disciplines have developed different definitions and measurement instruments that may not necessarily represent the wholeness and scope of the concept. The profusion of descriptor terms associated with ethical sensitivity and the methodological difficulties and limitations of previous inquiry emphasize the need for using a research method capable of synthesizing available knowledge at its current level of development.

This review offers a limited synthesis of the theoretical descriptors and research findings which may help professionals to more fully comprehend the concept's meaning, nature, and complexity. A beginning clarification of the concept through systematic

comparison with its allied concepts is provided. The review identifies a need for further exploration of the costs and benefits of ethical sensitivity, the type and role of educational interventions, and the relationship between ethical sensitivity and other components of decision-making such as agency. These results highlight a need for more thorough articulation of the theoretical frameworks guiding research questions and of the research methods employed to explore ethical sensitivity.

Ethical sensitivity is currently a low-level, partially mature, emerging scientific concept. It is, however, a concept of significance to various professional disciplines and must be evaluated in light of its potential for contributing to shared disciplinary knowledge. Rigorous, comprehensive analysis is required to advance the utility of the concept for research, education, and ultimately practice.

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Chapter 2

THE STATE OF THE ART OF CONCEPT ANALYSIS

Concept analysis is a research strategy which involves systematizing information about a concept to appraise and enhance the concept's utility to a discipline. In nursing, methodological development in the area of conceptual inquiry has lagged behind other syntactical concerns in the pursuit of knowledge to guide practice. Concepts representing key phenomena of interest to the discipline have been identified but are at a partially mature level of development because they have been neither clarified nor used consistently in research, theory, practice, and policy. This limits the utility of the concepts to nursing, impedes disciplinary development, and, most importantly, may compromise the well-being of patients. For nursing to flourish within its mandate of enhancing health and comfort, it is imperative nursing build the base for a substantive body of knowledge for communicating nursing practice reflective of its goals. To this end, ongoing examination and development of concepts central to nursing are needed. However, the lack of attention to developing efficacious ways to strengthen the nursing conceptual base has contributed to over-reliance on and uncritical endorsement of approaches that repudiate rather than satisfy disciplinary need. As a consequence, the conceptual base for nursing will remain poorly developed with future studies unable to build upon the current level.

The purpose of this article is to evaluate the major methods for analyzing partially mature concepts in nursing research. The significance of concepts to the discipline, the impetus for concept development, and the evolution of concept inquiry in nursing will be discussed. Various methods that use the literature as data to analyze partially mature

concepts will be examined in terms of study purposes, procedures, underlying paradigmatical ontological and epistemological assumptions, adequacy of the direction provided to researchers, limitations, and contribution to nursing knowledge and theory development. This work will extend the critique of concept analysis methods begun by Morse and her colleagues (Hupcey, Morse, Lenz & Tason, 1996; Morse, 1995; Morse, Mitcham, Hupcey & Tason, 1996). It will include the Morse Criterion-based method for exploring pragmatic utility, compare the philosophical underpinnings of the research paradigms associated with each method, and evaluate the direction offered to researchers.

The Significance of Concepts to the Discipline

Concepts guide a discipline in that they form the basic units comprising theory and linking theory, research, and practice (Morse et al., 1996). Concepts are stable organizations achieved through the utilization of rules of relation such as applying the principle of similarity to identify a class of elements or seeing fresh instances of a concept (Bolton, 1977). As shared knowledge, concepts facilitate identifying, communicating, and recognizing complex phenomena. Concepts connect science and the world by enabling data to be organized and abstracted or organized, measured, and tested (Morse et al., 1996).

Nursing involves the art, science, and practice of alleviating suffering and of helping people to safeguard and improve their health and well-being (e.g., Travelbee, 1971). Nurses are therefore interested in behavioural concepts that assist them to understand both the health and illness experiences of their patients and the nursing contribution to patient welfare. Behavioural concepts are difficult to define because they may not be directly perceived, described, measured, or demonstrated by a concrete

display of what they represent. Their subjective nature can be only indirectly inferred, and yet, there is a need to examine and enhance comprehensiveness of these concepts that describe patient reality and explicate essential qualities important to nurse-patient relationships. According to Knafl and Deatrick (2000, p. 365):

> Concepts shape how we think about the patients, families, and communities with whom we work. They direct our observations and our actions based on those observations. Important in their own right . . ., they merit our careful attention and nurturance.

The level of concept development within a discipline is an indication of the maturity of the discipline. A discipline is responsible for and establishes itself by building its scientific research base from a set of well developed key concepts related to its phenomena of interest (Donaldson & Crowley, 1978; Toulmin, 1973). Without this clear conceptual foundation, inquiry will be thwarted. Confusion will result from the use of the same term with implicitly or explicitly different meanings (Rodgers, 1989b). The quality of subsequent research and theory construction will be weakened.

The Impetus for Concept Analysis in Nursing

The first set of concepts for nursing was identified by Florence Nightingale who articulated the role of environment and observation in caring for the sick person (Nightingale, 1946). The task of descriptive study of other phenomena important to nursing practice but at the level of lay knowledge began in the mid-20th century (Norris, 1982a). These early efforts included clarification of concepts such as anxiety (Gregg, 1952; Hays, 1961), reassurance (Gregg, 1955), and loneliness (Peplau, 1955). Although this initial work was undertaken by nurses limited in methods of concept analysis, theory

construction, and research experience, it continues to offer insights to nurses and students because the early nurses were able to relate their practice to the uniqueness of nursing.

The impetus for concept clarification in nursing may have been influenced by four factors. The first concerned nursing's struggle to define itself to those within and outside the profession. At the internal level, focus was directed on developing a specialized knowledge base that could be taught to students and used to distinguish professional educational preparation from technical training. Externally, the struggle involved differentiation of nursing from the long established profession of medicine through identifying independent nursing functions and basing practice on holism and humanism rather than the medical model (Norris, 1982a). In their urgency to establish the credibility of nursing as a profession, nurse scholars bypassed descriptive research to engage in experimental research (Cull-Wilby & Pepin, 1987). Yet, disciplinary progress is potentially hampered when concepts of ambiguous relevance or meaning to nursing are used in research and theory activities. For instance, importing the concept of grief from the discipline of medicine and identifying grief on the basis of symptoms alone without determining its relevance to nursing practice as Cowles and Rodgers (1991) had initially done, inadequately informs nurse-patient interactions. The nursing struggle might reflect the tension between rationalism and empiricism. Rationalism is the view that knowledge or the contents of concepts is superior to the information that sense experience can provide; empiricism is a complementary school of thought maintaining there is no source of knowledge or concepts other than sense experience (Markie, 2004). Interestingly, the nurse scholars relied on experience (empiricism) to define the nature of nursing, and on reason (rationalism) to inform the relations among these ideas about nursing.

The second factor concerned the establishment of federal funding to provide doctoral education to American nurses (Kalish & Kalish, 1973). Scholarship programs included the individual Special Nurse Research Fellowship, the Nurse Scientist Graduate Training program for institutions, and later the individual and institutional predoctoral and postdoctoral awards available through National Research Service Award legislation (National Institute for Nursing Research). This enabled nurses to undertake research preparation in social, behavioral, and biological disciplines. These doctorally prepared nurses re-entered nursing like anthropologists, psychologists, sociologists, and biologists, bringing with them concepts and research methodologies from those disciplines. While having nurses prepared as researchers in various social sciences was essential for nursing to more quickly achieve professional status, the borrowed research methodologies had not been created for application in nursing contexts. There was a need to relate the conceptual frameworks of the other disciplines to the conceptual foundation reflecting the aims, values, and philosophy of nursing (Norris, 1982b).

The third factor that fostered analysis and refinement of concepts occurred in the 1970's when theory development became a national goal in American nursing. Curricula for nursing degree programs were required to have underlying nursing theoretical frameworks (National League for Nursing, 1972). These theories, however, were deemed to be inadequately defined and too abstract to guide educational programs (Schwartz-Barcott & Kim, 2000). For example, the language of the theories was too esoteric for practice (Holmes & Warelow, 2000; Kim, 1999). Thus, attention was directed toward developing the central concepts within nursing theories.

The fourth factor arose upon identification of the need to develop a comprehensive system to categorize nursing content for the purpose of validating nursing as a professional discipline capable of shaping a theoretical foundation reflective and enhancing of practice. An initiative for nurse theorists, researchers, and practitioners to work together to structure conceptual content which would be inductively derived from practice was implemented by a group of 100 nurses at the First National Conference on Classification of Nursing Diagnosis in 1973 (Gebbie & Lavin, 1975). However, a subsequent decision in 1976 at the Second National Conference to develop "diagnostic" labels solely from practice situations, without the benefit of theory, fractured theory from practice and research (Gebbie, 1976). The result was a lack of integration of newly developed categories into extant theory and a perception that theories are developed in isolation from practice and research (Young, Taylor & Renpenning, 2001). This movement to define concepts added upheaval to nursing's effort to develop knowledge for practice.

After reviewing the published research of nurses from 1950-1975, Batey (1977) identified the greatest limitation to be the conceptual phase (e.g., researcher use of an ambiguous concept in a study). In 1982, Norris articulated the need to develop and refine methods using logic or philosophy of science to study the concepts about which nurses require knowledge. From that point forward, a variety of methods (e.g., Wilsonian-derived, Evolutionary, and Criterion-based) for analyzing concepts important to nursing were developed and used. Morse and her colleagues (Hupcey et al., 1996; Morse et al., 1996) subsequently launched into nursing literature, explicit critiques of the purposes, procedures, limitations, and products of the earlier methods. Continued critique of the

methods (including the Morse Criterion-based method) and the products of concept analysis is needed to assess disciplinary substance and syntax.

Evolution of Methods of Concept Analysis in Nursing

A method of concept analysis, adapted from Wilson (1963) who based *Thinking with Concepts* on the work of Wittgenstein, was further summarized and introduced into nursing by Walker and Avant in 1983. Walker and Avant reduced into eight steps, Wilson's eleven techniques for isolating a concept and implementing analytical processes. A variation of Wilson's method, developed by Chinn and Jacobs (1983), differed from the Walker and Avant method in that it attended to the feelings and values associated with words and presented a less linear format with more interaction between the steps. A further variation by Schwartz-Barcott and Kim in 1986 was created as a Hybrid model (based on philosophy of science, sociology of theory construction, and participant observation) to educate graduate students about theoretical development in nursing. The Hybrid model differs from the other Wilsonian-derived methods in specifying extensive review of the literature, using cases from clinical contexts, and including a fieldwork phase of data collection (Schwartz-Barcott & Kim, 1993). Of the Wilsonian-derived methods, the one developed by Walker and Avant (1983; 1988; 1995) has been used the most often in graduate curricula, specifically in doctoral level theory courses. Numerous completed concept analyses using the Walker and Avant method have been published.

Rodgers (1989a), after appraising the philosophical foundations of the previous approaches to concept analysis (e.g., Chinn & Jacobs, 1983; Walker & Avant, 1983), based her Evolutionary method on a cycle of concept *use* (definition and attributes),

significance (importance to solving problems of interest to the discipline), and *application* (characteristics of concepts in various settings, across time, and within particular contexts such as particular disciplines, cultural groups, and theories). Rodgers emphasizes the selection of literature to be reviewed (e.g., drawing selections from a computerized data base) and strict recording of decisions regarding sampling techniques and of researcher thoughts and perceptions during data collection and analysis (Rodgers, 1989a, 2000b). Concepts such as health policy (Rodgers, 1989b), grief (Cowles, 1996, 2000; Cowles & Rodgers, 2000; Rodgers & Cowles, 1991a, 1991b), and partnership (Gallant, Beaulieu & Carnevale, 2002) have been analyzed using the Evolutionary method.

The Criterion-based method to concept analysis was developed by Morse (1995; 2000) to analyze partially mature concepts. The method encompasses the technique of *critical appraisal* whereby analytical questions are formulated from and directed back to the literature to reveal implicit assumptions and reveal differences about the concept through its use by various authors or researchers subscribing to a number of perspectives. Critical appraisal enables exploration of the usefulness of concepts to a research program and to science. Concepts such as caring (Morse, Bottorff, Neander & Solberg, 1991; Morse, Solberg, Neander, Bottorff & Johnson, 1990), empathy (Morse et al., 1992), and intuition (Morse, Miles, Clark & Doberneck, 1994) have been analyzed to the place where they can begin to be integrated in qualitatively-derived theory.

Critique of Wilsonian-Derived, Evolutionary, and Criterion-Based Methods

The large number of published concept analyses in the nursing literature enables critique of the adequacy of conceptualizations and methods. Wilsonian-derived,

Evolutionary, and Morse Criterion-based methods are considered in terms of study purpose, procedures, philosophical underpinnings of the associated research paradigms, limitations, adequacy of direction to researchers, and contribution to nursing knowledge (see Table 2-1).

Study Purpose

According to Rodgers (2000b), the purpose of conceptual inquiry is to resolve a problem – a gap or inconsistency in disciplinary knowledge. Concept analysis should therefore start with delineating the nature of the problem intended to be addressed by the research. In comparing the purpose of each method in Table 1-2, the Morse Criterion-based method explicitly purports to evaluate conceptual adequacy through examining disciplinary use of the concept. The methods introduced by Walker and Avant (1983; 1995) and Rodgers (1989a; 2000b) focus on identifying the attributes of a concept. Chinn and Jacobs/Kramer (1983; 1987; 1995) aim to create meaning. Schwartz-Barcott and Kim (1993) provide a learning activity for students in graduate theory courses and "improve" the Wilson method.

Procedures

Concept selection. All except the Morse Criterion-based method begin with selecting a concept. There is little description of how to make the selection. Wilson's scholarly processes of *isolating questions of concept* (e.g., separating and prioritizing questions of fact and morality from those of concept structure) and considering *right answers* (e.g., distinguishing instances of the concept nearer to the "heart" of the concept from others less central) have been lost. The Morse Criterion-based method starts concept

Table 2-1

Comparison of Wilsonian-derived, Evolutionary, and Morse Criterion-based Methods of Concept Analysis

	Method	Purpose	Procedure
I. Wilsonian-derived Methods	Walker & Avant (1983; 1988; 1995)	To distinguish between defining and irrelevant attributes of a concept and to determine likeness and unlikeness between concepts	(a) Choose concept. (b) Determine rationale for analysis. (c) Identify all uses of concept. (d) Identify defining attributions. (e) Develop a model case. (f) Construct additional cases (which may include fictitious cases) of what counts/doesn't count as an example of the concept. (g) Identify antecedents and results. (h) Determine empirical referents.
	Chinn & Jacobs/Kramer (1983; 1987; 1991; 1995; 1999)	To create meaning by considering the word label, phenomenon represented, and associated feelings, values, & attitudes.	(a) Select concept. (b) Establish purpose for creating conceptual meaning. (c) Examine data sources. (d) Develop criteria for validating the soundness of the tentative conceptualization
	Schwartz-Barcott & Kim (2000)	To (a) educate graduate students and (b) improve on Wilson's method.	(a) Theoretical phase: - Select a concept. - Determine meaning and measurement of concept. - Choose working definition. - Search the literature. (b) Fieldwork phase to collect and analyze data. (c) Analytic phase to compile findings.
II. Evolutionary	(Rodgers, 1989a, 2000b)	To identify attributes of a concept through its common use to provide a foundation for further research.	(a) Select concept. (b) Determine realm for data collection. (c) Collect data re attributes and contextual basis (e.g., interdisciplinary, sociocultural, and/or temporal) of the concept. (d) Analyze the data. (e) Identify a "real life" model case. (f) Identify hypotheses and area(s) for further development.
III. Morse Criterion-Based	Morse (1995; 2000)	To evaluate the 'state of the art' of concept use by comparing and contrasting applications in particular disciplines, determining conceptual adequacy with competing concepts, and identifying gaps, inconsistencies, and boundaries.	The approach is based on guiding principles rather than a series of steps. (a) Clarify purpose of the analysis. (b) Select literature to ensure validity - organize literature. (c) Identify critical questions - comprehend topic - ask questions of key literature (d) Synthesize results - compile results

Table 2-1 (Continued)

Comparison of Wilsonian-derived, Evolutionary, and Morse Criterion-based Methods of Concept Analysis

	Philosophical Underpinnings	Limitations	Contributions
I. Wilsonian-derived Methods	*Positivist* research paradigm. View of concepts as "static" entities (Rodgers, 1989a; Wuest, 1994) with inherent truth which can be established through correspondence with a universal reality. Reliance on context-stripping and reduction to isolate the essence of concepts. Assumes that concepts do not change over time or across contexts.	Simplification of critical inquiry processes. Use of dictionary definitions and invented cases reduces validity and comprehensiveness. Emphasis on consistency of concept use across contexts is at the expense of comprehending the concept's internal consistency and fit with phenomena of interest to nursing (Morse et al., 1996). Little if any new knowledge has resulted (Morse, Hupcey & Penrod, 2005). No direction identified for further research about the concept (Hupcey et al., 1996).	Wilsonian methods widely used in nursing education. Provides writing exercise for doctoral students. The steps are easy to follow.
II. Evolutionary	*Interpretive* paradigm. Holds view of reality as constantly changing, interpretable only within a specific context. Concepts viewed as dispositional or continually subject to change. Truth value of a concept established by the coherence of the attributes within the clusters (Rodgers, 1994).	Identification of a single model case limits richness and is inconsistent with view of concepts as context-bound. Process appears linear. Validity threatened by sampling statistically as data adequacy not ensured. Opportunity to strengthen conceptual boundaries is lost by treating surrogate (identical) and related (similar) terms as outliers mentioned only in the findings or implications for further research.	Illustrates process of concept development through time and within a particular context. Inductive approach. Emphasizes selection of literature to be reviewed. Attempts to enhance credibility via systematic sampling (e.g., drawing selections from a computerized data base) and strict recording of sampling decisions.
III. Morse Criterion-Based	*Critical Theory* paradigm. Focus is on establishing the usefulness of a concept to a discipline or program of research. Probabilistic view of concepts. Analytical questions are not predetermined but derived from and asked of the literature.	Limited to partially mature concepts for which an adequate sample of literature exists. No comprehensive manual to guide approach. Requires a large work space to construct the giant matrix for viewing the whole. Cannot be accomplished on a computer screen.	Informs about the use and relevance of a concept to science. Extends knowledge beyond the boundaries of what is currently known by an individual discipline. Guides further research. Integrative rather than reduction of prior research about the concept.

analysis with clarification of the purpose of the inquiry. For example, Penrod (2001) saw the need to determine where the conceptualization of uncertainty fit within the scientific literature of various disciplines after identifying its emergence and theoretical relevance to nursing in a qualitative inquiry into the concepts of hope, enduring and suffering.

Processes. Concept analysis is presented as steps, phases, or principles. The Wilsonian-derived methods portray concept analysis as a set of steps to be followed. Although Rodgers describes the Evolutionary method as a nonlinear process, "formal" analysis is conducted after data collection rather than concurrently as it is in qualitative analysis (Rodgers, 2000b). Rodgers argues delaying analysis is justified to avoid reaching premature conclusions before all data is reviewed or available. However, separating data analysis from its collection jeopardizes reliability and validity because the back and forth movement of maintaining focus and systematically checking and fitting data to monitor and confirm interpretation is lost (Mayan, 2001). The Morse Criterion-based method presents guiding principles to be used at the discretion of the researcher (Morse, 2000). Morse does not promote adherence to steps as this may limit the cognitive effort and freedom needed to follow nuances emerging with various topics and contexts.

Data sources. All of the methods specify the literature as a data source to analyze the concept. In addition, Walker and Avant (1983, 1988, 1995) include using fictitious data in constructing cases of what does or does not exemplify the concept. Chinn and Kramer (1991; 1995; 1999) include as other sources of evidence visual images (e.g., drawings, photographs, cartoons), popular and classical literature, music, poetry, and people who work with the concept. Rodgers (Rodgers, 2000a) suggests researchers consider nondiscursive forms of data such as the performing arts. Schwartz-Barcott and

Kim (2000) supplement the data of the literature with interviews and field observations. Schwartz-Barcott and Kim (2000), Rodgers (2000b), and Morse (2000) all recommend cross-disciplinary sampling and consideration of the concept's transition over time.

Sampling. Schwartz-Barcott and Kim (2000) describe the need to search the literature, comparing and contrasting explicit and implicit definitions of the concept with a tentative definition, to identify the concept's essential nature. This is followed by a fieldwork phase of selecting a small number of cases to corroborate and refine the definition. The difficulty with this approach is that the nature of the complex behavioural concepts of interest to nursing may not be grasped until the researcher attains substantive comprehension of more than definitions. There is potential for error associated with data inadequacy. Rodgers (2000b) calls for systematic sampling of the literature by drawing selections from a computerized data base using standard means of probability, stratified, or random sampling (i.e., n = 30 or 20% of the total population). The difficulty with Rodger's approach to sampling is that it is not, to use Miles and Huberman's (1994) term "conceptually-driven" (p. 27) as it eliminates the logic and coherence needed for interpreting social processes or applications across contexts. Morse (2000) stresses the need for retrieving, examining, and cataloguing of "*all* the literature" (p. 350) relevant to the concept which includes (a) obtaining and reading entire articles rather than abstracts and (b) careful, computerized organization of the literature. Researchers using the Morse Criterion-based method purposively recruit literature to meet specific study needs.

Data analysis. As shown in Table 2-1, data are analyzed within the Wilsonian-derived and Evolutionary methods through constructing cases. These constructions may include identifying a single model or a real life case that provides an unfailing example of

the concept (Chinn & Kramer, 1995; Schwartz-Barcott & Kim, 2000; Walker & Avant, 1995). Antecedents (conditions that must be present for an instance of the concept to occur), results (outcomes of the concept's use), empirical referents (concrete evidence of the concept), and exemplars (anecdotes that capture the essence of the concept) are identified. Additional cases to delimit the concept may be constructed using the literature, the researcher's imagination, or observation and interview if following the Hybrid model of Schwartz-Barcott and Kim.

The Morse Criterion-based method of analysis does not develop model or alternative cases. Anatomy (structure), physiology (use), and maturity (level of development) of the concept are assessed against epistemological (clarity of definition, boundaries, attributes, preconditions, and outcomes), linguistic (use in context and across contexts), pragmatic (degree of operationalization), and logical criteria (clear differentiation from other concepts) to determine the state of knowledge and the usefulness of the concept for the research, theory, and practice of a discipline. Data are analyzed through synthesizing commonalities and differences in the answers to analytical questions derived from and asked of all relevant literature (Morse, 2000).

Rigor. Strategies to evaluate rigor are not described by Walker and Avant, Schwartz-Barcott and Kim, or Rodgers. The Chinn and Jacobs/Kramer method does include developing criteria specific to the concept under study to validate the adequacy of the resulting tentative conceptualization. Morse and her colleagues (1996) have developed an extensive set of criteria (i.e., extensiveness of data base, depth of analysis, strength of argument, validity, level of abstractness, and contribution to knowledge) for evaluating the reliability and validity of the concept analysis. One research team using the

Evolutionary method (i.e., Gallant et al., 2002) applied the Morse criteria for evaluating concept maturity.

View of Concepts within Each Method's Associated Research Paradigm

Wilsonian-derived methods are characteristic of the dominant positivist research paradigm (Rodgers, 1994; Wuest, 1994). Context is stripped to isolate the concept. Researchers strive to identify distinct boundaries and rigid conditions that clearly define examples of the concept. Wilsonian-derived methods, for the most part, present a view of concepts as static entities with truth value believed to be established through correspondence with a single objective reality. This realist ontology is reflected in the approach of Schwartz-Barcott and Kim (2000) to corroborate the theoretically defined concept through field work.

The Evolutionary approach to concept analysis portrays a dispositional view of concepts as habits or capacities for behaviours that may change over time (Rodgers, 2000b). Central to this perspective is an understanding that the meaning of a concept can be interpreted only within its particular context. The Evolutionary method represents the interpretive or constructivist ontology wherein reality is holistic and subjective, and multiple realities coexist. Despite this affiliation with the interpretive paradigm, aspects of the Evolutionary method (e.g., basing data adequacy on systematic rather than theoretical representation, using a single model case to represent the concept) convey positivist epistemology.

The Morse Criterion-based method offers a pragmatic view of concepts which combines probabilistic (clusters of attributes based on similarity or resemblances) with entity (attributes must meet stringent criteria to belong to a conceptual category)

perspectives (Morse, 1995). Literature is sorted in the most appropriate way to address research purpose. Concepts are critically examined and transformed to increase disciplinary usefulness (Morse, 2000). Researchers using the Morse Criterion-based method "push" (Morse, 2000, p. 334) beyond synthesis of isolated findings to enhance understanding and concept utility through exploring new insight and lines of questioning.

Limitations

Wilsonian-derived methods are limited by inadequate descriptions of method (Hupcey et al., 1996; Paley, 1996). Omitted are descriptions of the researcher's internal dialogue and of the integration of the procedural steps with each other (Hupcey et al., 1996). The Wilsonian-derived methods stress consistency of the concept's use across contexts but place less emphasis on understanding the concept's internal consistency (e.g., clear definition, well-defined boundaries with other concepts) and fit with other phenomena of interest within the nursing discipline (Morse et al., 1996). The Walker and Avant method ignores context (Paley, 1996; Rodgers, 1989a), minority perspectives (Wuest, 1994), and intellectual rigor (Hupcey et al., 1996; Morse et al., 1996). Use of dictionary definitions and invented cases reduces validity, comprehensiveness, and relevance for nursing (Hupcey et al., 1996). The Schwartz-Barcott and Kim Hybrid model lacks depth and utility because only one nursing situation is used (Morse et al., 1996). Researchers using the Walker and Avant method invariably conclude their articles by recommending that further research is needed about the concept, but they do not outline the direction for this research (Hupcey et al., 1996).

Limitations of the Evolutionary method relate to sampling and analysis techniques. Basing sample selection on statistical rather than theoretical

representativeness may compromise validity as literature chosen randomly may not fully depict the concept. This sampling procedure does not ensure data adequacy, for Rodgers (2000b) reports that literature beyond that used to analyze the dimensions of the concept may be required to identify a model case. As well, identification of a single case from the data base limits richness (Morse et al., 1996). Use of standard thematic analysis to establish the attributes of the concept may reduce the internal intellectual dialogue needed to comprehensively develop concept structure. For example, surrogate (identical) and related (similar) terms were treated by Cowles and Rodgers (2000) as data in "final form" (p. 107), analyzed by frequency counts and excluded from comparison with the concept under study.

The limitation of the Morse Criterion-based method is that it is new and evolving. Its use is limited to the study of partially mature concepts about which an adequate and appropriate sample of literature is available. Analysis requires a large work space to view and successfully synthesize the answers to analytical questions asked of the literature.

Adequacy of Direction to Researchers

Developers of the Wilsonian-derived methods have refined descriptions of their approaches in response to their own thinking, feedback from those using or critiquing their approaches, and new findings in the literature. Chinn and Jacobs substantially modified the second edition of *Theory and nursing: A systematic approach* (1987) to show how the esthetic, ethical, and personal patterns of knowing introduced to nursing by Carper (1978) complement scientific empiric knowledge. Changes to the Schwartz-Barcott and Kim Hybrid model from its 1993 to 2000 description have been minor (e.g., appearance of the figure, additions to the list of concepts analyzed using the Hybrid

model, and addition of a fifth example of the usefulness of the model for research and practice). It is unclear why selected concepts cited in 1993 (i.e., adaptation, parenting, hope, faith, pain, and caring) do not appear on the 2000 list. The Walker and Avant method of concept analysis has not changed significantly from its first (1983) to third (1995) editions. Ridner (Ridner, 2004) acknowledged choosing the Walker and Avant method because of its simplicity. However, ease in use must be judged in tandem with the quality and usefulness of results.

The Evolutionary method offers explicit directions. A potential problem is that researchers unfamiliar with standard qualitative procedures may erroneously believe that probability sampling will saturate theoretical categories. This aspect of the method requires clarification. In response to criticism, Rodgers (2000b) has shared her thinking regarding why she does not see a need for conducting data collection and analysis together as a unit to ensure rigor. Readers may agree or disagree. The strength of the Evolutionary method is Rodgers' articulation of its philosophical underpinnings because this enables researchers to understand the view of concepts and the findings resulting from using the method.

The Morse Criterion-based method has drawn criticism by Baldwin (2003) who determined that while the method is comprehensive, it is complex for novice researchers. Morse does not downplay the intense cognitive and intellectual effort required to advance disciplinary knowledge. Her presentation of a set of guiding principles to be used wisely and thoughtfully may be more daunting to researchers than a "recipe card" approach to concept analysis. Lack of a comprehensive handbook may deter researchers who must piece together content from discrete articles and chapters. The potential for

misinterpretation must be monitored, given the newness of the method. For example, to explore the concept of creativity, Fasnacht (2003) departed from the Morse Criterion-based method by using stratified random sampling and relying on a number of secondary sources. Fasnacht aptly identified the resulting threat to validity from seeking population representativeness rather than data adequacy.

Contribution to Nursing Knowledge and Theory Development

The abundance of published concept analyses using the Walker and Avant method gives the impression that much work is being done or the nursing knowledge base is being developed; however, there is little evidence of significant findings being produced from this method. A trend toward drawing on larger numbers of articles is noted in recent published concept analyses (Aita & Snider, 2003) using the Walker and Avant method. It is of concern that invented nonhuman cases continue to be fabricated (e.g., Ridner, 2004) when extensive literature is available (Weaver, 2005a). Invented cases were originally devised by Wilson (1963) as a strategy to teach high school students to expand thinking outside of their ordinary experience. The appropriateness of continuing to use obviously invented or constructed cases to build nursing's knowledge must be determined.

The Evolutionary method contributes understanding of the concept across context. For instance, Breen (2002) determined the level of consensus and variation in the concept of chronic pain across disciplines of nursing, psychology, and neurophysiology. Knafl and Deatrick (2000) reported nursing staff benefited from on site dissemination of findings from concept analysis of normalization. The nurses were able to recognize family behaviour as "normalization" rather than as "denial" and to validate clinical

assessment using criteria developed by the researchers. It is not clear if this contribution of concept analysis research to practice resulted from direct dissemination of findings to practicing nurses or from advantages of the method.

The Morse Criterion-based method grounds techniques for concept development in thorough review of the literature and prepares a path for subsequent research (Knafl & Deatrick, 2000). The method has the potential to overcome limitations associated with the other methods because it does not base knowledge needed for nursing practice on fictional or superficial definitions and it does not limit understanding to use of one single nursing situation or model case. The Morse Criterion-based method is based on a process of questioning that is data driven not translated from preconceived questions. It yields thick description of a concept's internal structure, interface with other concepts, and application across multiple contexts. Through use of critical appraisal, McCormick (2002) identified specific areas for future research to advance the utility of the concept of uncertainty for nursing practice (i.e., to explore the relationship between uncertainty in illness and perceived control, to distinguish situations in which nurses should try to eliminate uncertainty from those in which they should promote it).

Discussion

Enhancing concept maturity is the goal of both concept analysis and disciplinary knowledge development. The credibility of nursing as a professional discipline is irrevocably linked to its capacity for developing and the level of maturity of its conceptual base. Nursing researchers have developed various methods to build disciplinary knowledge by analyzing concepts pertinent to practice. These methods reflect the art and science of the discipline. A goal of the nursing discipline is to develop

concepts that are mature or ready to be used in research, practice, and theory construction.

The focus of Wilsonian and Evolutionary methods on developing concept components and meaning, and on generating data from field work, art sources, or researcher imagination suggests that these methods may have been designed for analyzing concepts that are immature. Concepts that are immature are inadequately defined, not clearly distinguished from other concepts within a phenomenon, and may or may not be used in practice and research settings (Morse et al., 1996). Because immature concepts may not be well represented in published disciplinary literature, they require qualitative approaches to further their development (Morse et al., 1996).

The Morse Criterion-based method as appropriate for analyzing concepts that are partially-mature, that is, concepts that may have ambiguous meanings and inconsistent application in research and practice (Weaver, 2005b). Comprehensiveness of partially mature concepts can be developed using the scientific literature if an adequate body of literature about the concept is available. Advantages of the Morse Criterion-based method are rigor based on the extensiveness of data, well-developed criteria for assessing concepts, and intellectual processes of critical appraisal for asking analytical questions and synthesizing results.

A finding of this critique is that researchers may choose the method of concept analysis for ease of use. Therefore, researchers need to ask themselves: Will a method selected because it appears simple to follow effectively help advance the science of the discipline? It is important to keep in mind Knafl and Deatrick's observations of the benefit to nurses resulting from researcher dissemination of findings to the practice level

(Knafl & Deatrick, 2000). This indicates the need to choose method on the potential contribution of findings to practice.

A further finding of this critique is that the criteria developed by Morse and her colleagues to evaluate concept maturity have been used by researchers to assess concepts analyzed by methods other than the Morse Criterion-based method. This suggests that the Morse criteria for concept maturity are relevant for evaluating the products of concept analysis using other methods. An advantage of using the Morse set of criteria is that the direction for further research about the concept is based on the level of the concept development.

This critique accentuates the need for researchers to adequately describe and evaluate the method as well as the substantive findings of concept analyses. Often the literature lacks description of how a method was used. For methods to evolve, the commentary (or confessional) of what was done, including any changes made to the method, is needed. Records of what works and does not work can direct method development. In this way, concepts and methods can be carefully developed.

Conclusions

The intent of concept analysis inquiry in nursing is strengthening the disciplinary conceptual base to inform theory construction, research, education, and practice. The three major methods of concept analysis used by nurses are Wilsonian-derived, Evolutionary, and Morse Criterion-based. Differences between each method's view of concepts and approaches to data collection and analysis result from underlying ontological and epistemological assumptions associated with a positivist, interpretive, or critical social theory underpinnings. Researchers, educators, and clinicians will need to be

mindful of the contribution and limitations of each method in preparing for inquiry and interpreting results of concept analysis research. It is not the intent of this critique to embroil nursing in either/or debates regarding feasibility of individual methods. Tolerance, appreciation, and evaluation of ongoing efforts to refine nursing syntax and to develop nursing science are recommended. At the same time, it is hoped that the findings of this critique will stimulate dialogue and questioning of the direction and effectiveness of the efforts to meet disciplinary knowledge need.

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Chapter 3

INSIDE THE MORSE CRITERION-BASED METHOD OF CONCEPT ANALYSIS: USING ANALYTICAL QUESTIONS TO EXPLORE ETHICAL SENSITIVITY

The strength of inquiry needed to explore pragmatic utility of concepts significant to professional disciplines depends on asking analytical questions. When formulated from indepth understanding of the literature, analytical questions guide analysis through synthesis of data to push beyond isolated findings and individual disciplines to gain new insight, lines of questioning, and direction. The purpose of this article is to describe the role and technique of using such questions to analyze the concept of ethical sensitivity in nursing and other professional practice. An overview of the guiding principles and the process of critical appraisal which characterize the Morse Criterion-based method of concept analysis are provided. The emergence of analytical questions and the challenge to manage these questions that become part of, yet remain distinct from, the data are described. Benefits and limitations of asking analytical questions are discussed. A taxonomy illustrating the depth and usefulness of the results from synthesizing answers to the analytic questions is included.

The Morse Criterion-Based Method

The Morse Criterion-based method of concept analysis is a method for exploring pragmatic utility or usefulness of a concept to disciplinary research, science, and practice (Morse, 1995, 2000). The method is appropriate for analyzing concepts that are partially mature. Partially mature concepts fall between less developed immature concepts and

well developed mature concepts in terms of definitions, practical and scholarly applications, status in scientific literature, and research potential (see Table 3-1).

Table 3-1

Classification of Concept Maturity by Dimensions of Concept

		Level of Concept Development		
		Immature	**Partially Mature**	**Mature**
Dimensions of Concept	**Definition**	Inadequate (Morse, Mitcham, Hupcey & Tason, 1996). Elusive.	Multiple definitions or problematic definitions. Ambiguous meaning. Confusion with use.	Clear. Precise scientific meaning (Morse, Mitcham et al., 1996). The meaning is comprehensive and agreed upon by scholars in the discipline.
	Application in Practice, Research, and Theory	May or may not be used in practice and research settings. May not be clearly distinguished from other concepts within a phenomenon.	Used inconsistently in practice and research. May not hold boundaries in combination with others (Morse, Mitcham et al., 1996).	May or may not be used consistently in practice and research (Hupcey & Morse, 1995). May be combined with others in theory (Morse, Hupcey, Penrod & Mitcham, 2002).
	Availability of Literature	Scant scientific literature available about the concept (Morse, Hupcey, Mitcham & Lenz, 1996). The concept may not be well represented in published disciplinary literature.	Scientific literature about the concept available within a particular discipline or across a number of disciplines (Morse, 2000).	Scientific literature provides clear description of the concept (Morse, Mitcham et al., 1996).
	Appropriate Type of Research	Requires qualitative inquiry for concept identification, development, correction, or delineation (Morse, Hupcey et al., 1996).	May be developed through methods of concept clarification, comparison, or correction using the literature as data (Morse, Hupcey et al., 1996).	May be used in quantitative inquiry for validation, refinement, and measurement (Morse, Hupcey et al., 1996) or in qualitative inquiry.

In comparison to mature concepts which are clearly, precisely, and comprehensively defined and to immature concepts which are inadequate and elusive, partially mature concepts may have differing or problematic definitions, ambiguous meaning, and confusion in use. Partially mature concepts may be used inconsistently in practice and research. Although they are distinguishable from other concepts within a phenomenon, partially mature concepts may not hold their boundaries when combined with other concepts in theory. When adequate scientific literature is available within a particular discipline or across a number of disciplines, a partially mature concept may be further developed using the literature as data.

Guiding principles and the process of critical appraisal are used within the Morse Criterion-based method to explore the concept. The principles guide clarification of study purpose, selection of adequate and appropriate literature, comprehension of topic, and synthesis of results. Critical appraisal involves formulating and asking questions of the literature and synthesizing results. The process is complex. Principles and process will be discussed separately and then together, using examples from an exploration of the concept of ethical sensitivity.

Guiding Principles for Exploring Pragmatic Utility

Clarification of study purpose. The need to explore ethical sensitivity originated from a previous qualitative study wherein women perceived recovering from eating disorders to be impeded by ethical violations on the part of professionals managing their care (Weaver, 2001). The women said things like "If only they would have been more sensitive to me." The women were blamed (e.g., "You shouldn't be like this. It's your

own fault"). They felt "nobody wanted to listen", "consult me," "do anything [when I was feeling suicidal]," "believe [me] when I said I never purged," or "treat [me] with respect" (Weaver, 1999-2000. Unpublished data). Because these data fell under the categories of the Canadian Nurses Association Code of Ethics for Registered Nurses, there was interest to explore ethical sensitivity, an aspect of professional helping capable of informing ethical decision-making and care delivery.

The study purpose was further clarified when preliminary review of the literature pertaining to ethical sensitivity revealed multiplicity of descriptor terms and definitions that captured aspects of but not the entire concept (Weaver, 2005). Similar to the tale of "The Six Blind Men and the Elephant" in which each blind man conceptualized the elephant differently depending on which part of the elephant he touched, "blind" researchers have tended to describe ethical sensitivity by its components of affect, skill, knowledge, cognitive ability to listen and perceive, or responsibility (see Figure 3-1). This has resulted in limited comprehension of the whole. Therefore, the research objective was to understand the meaning, utility, relevance, dimensions, and applications of the concept of ethical sensitivity.

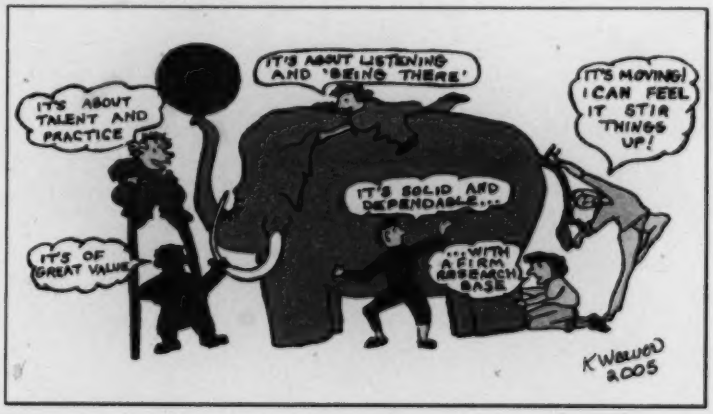
IT'S ABOUT LISTENING AND 'BEING THERE'
IT'S ABOUT TALENT AND PRACTICE
IT'S MOVING! I CAN FEEL IT STIR THINGS UP!
IT'S SOLID AND DEPENDABLE...
...WITH A FIRM RESEARCH BASE
IT'S OF GREAT VALUE
K WELLWOOD 2005

Figure 3-1. Six blind researchers and the concept of ethical sensitivity.

Validity in Selection of Literature Validity is a process of ensuring that what was intended to be studied was actually studied (Burns & Grove, 2001). To ensure validity in the ethical sensitivity study, multiple parameters all fields searches of the on-line professional databases of *CINAHL, Medline, Philosopher's Index, ERIC, PsychINFO, Academic Search Premier, Business Source Premier, Communication & Mass Media, ATLA Religion Data Base, Social Sciences Abstracts,* and *Legal Periodicals & Books* were conducted to locate pertinent literature. Initially to gain the broadest range of definitions, the search included similar (e.g., altruism, receptivity) and opposite (e.g., insensitivity, desensitization) concepts. It specified professional practice (i.e., profession, clinical, dentistry, nursing, physician, doctor, practitioner, therapist, lawyer, business, manager, medical, social work, psychology, clergy, priest, theology, teacher, educator, auditor, accountant, bioethics, political science, social science, and philosophy). This broad search strategy identified too vast a number of articles to render the task of analysis manageable. To this end, the search strategy was refined to delineate less pertinent from more beneficial literature. The fields were restricted to articles with such terms as *ethical sensitivity, moral sensitivity, ethical perception, moral perception, ethical sensibility, moral sensibility,* or *ethical intuition* in titles or abstracts by using the search term (ethic$ or moral$ or clinical) and (sensitiv$ or percept$ or sensib$ or intuit$) .ti,ab. when data bases permitted. The work of particular authors who significantly contributed to the knowledge base of ethical sensitivity through programs of research was sought using the "author search" option in individual databases. General internet search engines (e.g., *Google* and *Findarticles*) were accessed to locate professional literature published in the lay domain. These more general searches contributed numerous citations, the abstracts of

which were read to determine usefulness and depth. An initial sample of 278 articles was located using the above search strategy.

This search strategy was developed to identify literature which specifically focussed on the concept under study. It did not attempt to locate literature in which the concept was not named or which used different concept labels. Neither was it intended to search prior to the use of the term. Inclusion criteria were accessibility, relevancy (i.e., must contain an explicit or inferred definition of the concept), and usefulness to the emerging conceptualization. As the study progressed, additional literature was included through seeking primary sources of data and ongoing computer and manual searching. Endnote,[b] a computerized bibliographic retrieval system, was used to organize the literature. A total of 200 articles, books, and chapters constituted the study sample (see Table 3-2).

Comprehension of Topic. Comprehension was attained through examination of the literature to uncover authors' overt and covert assumptions and perspectives. Comprehension in the ethical sensitivity study involved coding, sorting data into categories, and evaluating anatomy (internal structure), physiology (use), and maturity. The use of *NVivo*[c] facilitated coding, categorizing, recording, and linking data and ideas.

Sorting. Data were sorted according to the purpose of the inquiry, that is, by disciplinary perspective and components of the concept (e.g., definitions, preconditions [antecedents], attributes [characteristics], outcomes, and applications). Allied concepts (i.e., concepts that are similar to the concept under study or that partially share attributes) were sorted to compare with each other and with ethical sensitivity to determine concept

[b] Available through ISI Web of Knowledge RESEARCHSOFT
[c] Data management system available through QSR International Pty Ltd

Table 3-2

Literature Sample Base

Data Base (Author with program of research)	Initial Sample	Sources Used
CINAHL (Lutzen, Nortvedt, Scott)	23	42[a]
Philosopher's Index (Blum)	58	21
Proquest	47	10
Social Sciences	32	10
Academic Search Premier	104	12
ERIC (Brabeck, Clarkeburn)	34	11
Medline (Baldwin, Bebeau, Hebert, Self)	42	24
PsychINFO (Rest)	97	18
Legal	27	7
Business (Shaub, Sparks)	72	15
Communication & Mass Media (Lind)	14	8
ATLA Religion Data Base (Narvaez, Callahan)	18	9
Findarticles	14	2
Google	2	0
Digital Dissertations	18	1
Total number of references	278	200

[a] Number increased by incorporating primary sources and ongoing computer and manual searches.

boundaries. Care was taken to ensure data adequacy in each sorted pile. Sorting via disciplinary perspectives was important as ethical sensitivity was conceptualized differently in each discipline. Figure 3-2 illustrates the processes of sorting and coding used to explore ethical sensitivity.

Coding. Each piece of literature included in the study was examined for biases and assumptions underlying authors' definitions of ethical sensitivity, variables used for its description and measurement, and the fit between conceptual and operational definitions and clinical application. Entire articles rather than abstracts were obtained and

read. Reading began the process of data transformation. As shown in Figure 3-2, data of interest were coded by highlighting and labelling.

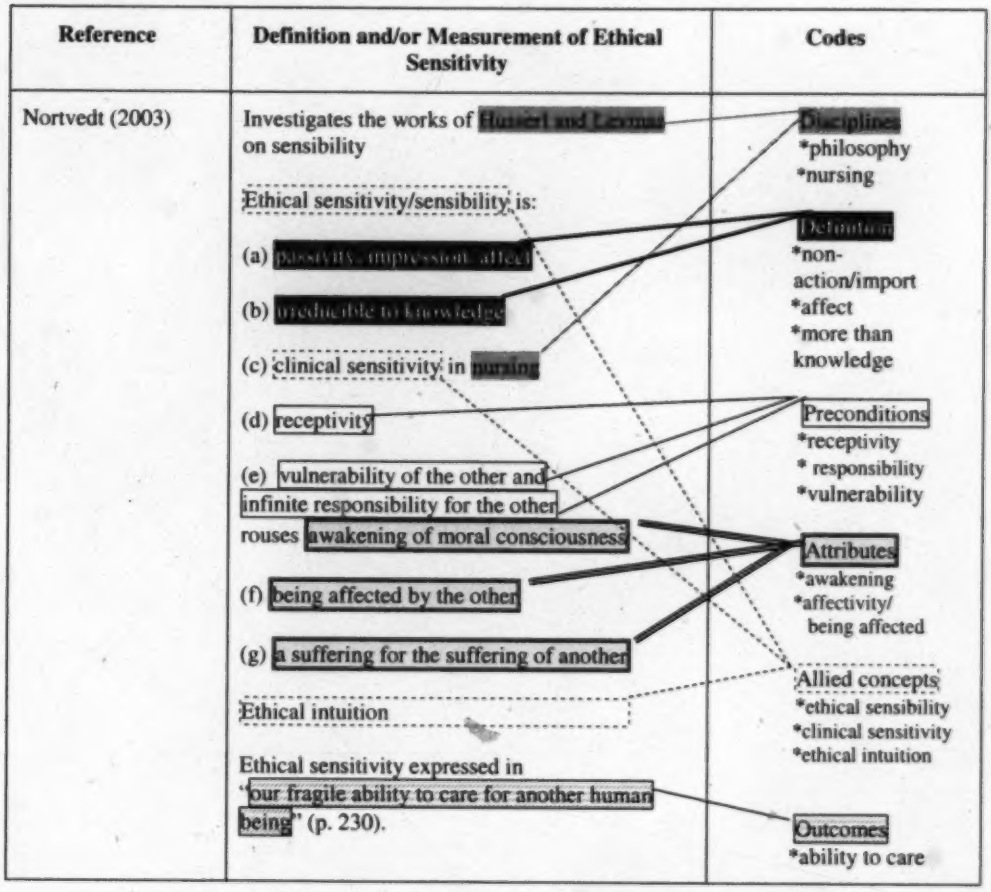

Figure 3-2. Example of Sorting and Coding the Literature

Anatomy of the concept. Anatomy is the internal structure of the concept. Assessment of anatomy involved examining definitions, preconditions, attributes, boundaries, and outcomes (Morse, 1995). These components of concept anatomy are defined in Table 3-3. In the assessment of concept anatomy, ethical sensitivity was determined to be an emerging or partially mature concept with competing, incomplete

Table 3-3

Anatomy of the Concept of Ethical Sensitivity

Dimension	General Assessment[b]	Assessment of Ethical Sensitivity
Definition	Degree to which concept is communicated enabling different people or the same person at different times to agree that something is an instance of the concept (Berthold, 1964). **Everyday concept** - Common dictionary meaning. **Scientific concept** - Consensually defined within a scientific community (Batey, 1977; Becker, 1983). ***Immature/Emerging*** — Lacks clarity/Poorly understood; Ambiguous (e.g., competing definitions, definitions skimpy, inadequate, dictionary) ***Mature*** — Clear; Unambiguous; Consensual	Competing/incomplete definitions Scientific concept Emerging.
Preconditions	Circumstances that must be present for the concept to develop or the behaviours that distinguish the characteristics to occur. In quantitative research, preconditions are the independent variables. ***Immature/Emerging*** — Not identified ***Mature*** — Identified fully	Suffering & vulnerability cues, relationship, receptivity, & responsiveness are clearly identified preconditions. Used as dependent variable with education as independent variable. Emerging. Not all circumstances identified.
Attributes	Features present in instances of the concept. Must be abstract enough to define the concept regardless of the context yet unique enough to differentiate concept from allied concepts. ***Immature/Emerging*** — Not identified ***Mature*** — Clearly identified	Attributes: moral perception, affectivity, and dividing loyalties identified in all instances of concept. Emerging - relationships between attributes and their components not clear.
Boundaries	Separateness of the concept from others. May be fuzzy, merge or overlap (and thus share attributes) ***Immature/Emerging*** — Not known ***Mature*** — Delineated	Used interchangeably with allied concepts (e.g., moral sensitivity, ethical intuition, ethical perception, ethical sensibility).
Outcomes	Results or consequences from utilization of the concepts. In quantitative work, outcomes are the dependent variables. ***Immature/Emerging*** — Not identified ***Mature*** — Identified fully	Outcomes of client comfort & well-being, professional learning, and integrity - preserving compromise identified. Role of negative consequences (e.g., exploitation, personal & moral distress) not clear.

[b] Source: Morse, J. M. (1995). Exploring the theoretical basis of nursing using advanced techniques of concept analysis. *Advances in Nursing Science, 17*(3), 31-46.

definitions. Full explication of the conditions under which ethical sensitivity occurs was lacking. Attributes of moral perception, affectivity, and dividing loyalties were identified but relationships between them and their components were not clear. Ethical sensitivity was used interchangeably with its allied concepts (e.g., moral sensitivity, ethical intuition). Outcomes of client comfort and well-being, professional learning and transcendence, and integrity-preserving compromise were identified. However, negative consequences which can include emotional overload, exploitation, personal and moral distress were scantily considered with regard to ethical sensitivity.

Physiology of the concept. Physiology or action of the concept was explored by examining various applications of ethical sensitivity in practice, theory, and research as described by Morse (1995; 2000). Striking differences were revealed in how ethical sensitivity was conceptualized within and across disciplines. Table 3-4 portrays the physiology of the concept across nursing, medicine, and business/accounting. Table 3-4 illustrates differences in how ethical sensitivity was conceptualized (e.g., as cognition, skill, and knowledge in medicine compared to cognition, affect, and responsibility in accounting/business). Differences were found in the perspectives which were studied (e.g., predominately students in medicine), types of settings, and instruments used in measurement. Ethical sensitivity was most often evaluated as responses to real life or hypothetical vignettes portraying dilemmas (i.e., a choice between two or more equally good or bad options) or violations (i.e., violation of rights and harm to stakeholders). The vignette content portrayed ethical sensitivity as a *negative* concept, that is, ethical sensitivity would not be applied to a situation if people were behaving ethically. Missing was conceptualization of ethical sensitivity as a proactive component of practice. In

nursing, the Lutzen Moral Sensitivity Questionnaire (MSQ) was used in addition to scenario based instruments. Quantitative study has predominated the field with a growing body of philosophical and case study inquiries.

Table 3-4

Physiology of the Concept of Ethical Sensitivity across Three Disciplines

Discipline	Nature	Perspective	Setting	Instruments	Methods
Nursing (n*=47)	Affect Cognition Skill Responsibility Knowledge	Bedside nurses, nurse practitioners, students	Psychiatric -mental health, medicine, surgery, ER	6 Scenarios: 3 dilemmas, 2 violations, 1 control. MSQ (attitude survey)	Qualitative (GT, phenomenology) Case study Philosophical Quantitative (descriptive, correlational)
Medicine (n=19)	Cognition Skill Knowledge	Students in all but 1 study	General practice	15 Scenarios: 9 dilemmas, 5 violations, 1 control	Quantitative (experimental, descriptive via neuro-imaging) Philosophical
Accounting & Business (n=15)	Cognition Affect Responsibility	Accountants, auditors, managers, students, clients	Small, mid, large-sized organizations Cultures	62 Scenarios: (41 dilemmas, 21 violations)	Quantitative (experimental, descriptive correlational)

*n= number of articles

Maturity of the concept. Maturity or readiness of the concept for research was evaluated by establishing the degree of the concept's coherence with the following principles: epistemological (clear description of definition, preconditions, attributes, boundaries, and outcomes), pragmatic (how well the concept is operationalized; its usefulness to and fit with other phenomena of interest to the discipline), linguistic (the consistency of the concept's use in and across contexts), and logical (how well the

concept holds its boundaries through integration with other concepts). The evaluation of the maturity of ethical sensitivity is shown by Table 3-5. Epistemologically, ethical sensitivity was found to be partially mature because many definitions were present and greater explication of preconditions, attributes, and outcomes were needed. Pragmatically, all the professional disciplines conveyed ethical sensitivity as an aspect of decision-making. Business, law, and nursing were concerned with client satisfaction; nursing and education were concerned with attrition. Although the multiple theoretical

Table 3-5

Maturity of the Concept of Ethical Sensitivity

Principle	Immature	Partially Mature	Mature	Ethical Sensitivity
Epistemological	No definitions. Inadequate definitions.	Multiple competing definitions.	Well defined. No competing concepts.	Many definitions. More needed re dimensions.
Pragmatic	Dubious fit. Not operationalized.	Partial fit. Partially operationalized.	Fits with phenomena. Operationalized.	Decision-making. Client satisfaction. Attrition.
Linguistic	Confusion.	Partially linked to context.	Integrated into context.	Many descriptors. Professional vs. student vs. client.
Logical	Not hold boundaries.	Beginning linkage to other concepts.	Used in theory.	Partially mature concept. Not used with other concepts.

Source: Morse, J.M., Hupcey, J. E., Penrod, J., & Mitcham, C. (2002). Integrating concepts for the development of qualitatively-derived theory. *Research and Theory for Nursing Practice: An International Journal, 16*, 5-18.

descriptors and conceptualizations for ethical sensitivity evident across disciplines could indicate linguistic immaturity, that was not the case as all these descriptors were components of ethical sensitivity. The differing perspectives of professionals, students, and clients required synthesis. For example, findings that clients recognize when professionals are not ethically sensitive suggest professionals must act in certain ways to be ethically sensitive. Logically, ethical sensitivity was introduced as a concept in 1982 and has not yet been well linked with other concepts.

Synthesis of results A giant matrix was constructed for viewing the data as a whole. The analytical questions formed the rows; the disciplines formed columns. Responses to the questions were compared and integrated. In keeping with standard qualitative inquiry, conflicting answers were treated as negative cases (i.e., examples that do not initially fit the pattern being discovered in the data). Negative cases force researcher thinking about the data in new ways and contribute to denser conceptualization when saturated (Mayan, 2001).

Process of Critical Appraisal

Critical appraisal involves intense scrutiny of the literature and formulation of questions to guide induction and analysis. The questions comprise a series of intellectual, analytical, and creative processes for transforming data from the level of concrete, individual study findings to that of new knowledge and synthesized results. The questions are the driving force for exploring the concept and enhancing its comprehensiveness.

Initial questions. Initial questions emerge naturally from the beginning of the inquiry and continue throughout the research process. They aid application of the

principles of clarification, validity, and comprehension. They facilitate induction of data and enable gaps and inconsistencies to be identified. They precede analytical questions.

Analytical questions. Analytical questions emerge later in the analysis once the researcher has attained a comprehensive grasp of the concept. Analytical questions require intensive thinking about the data. Analytical questions force previously undiscovered insights from the data. They are levers that allow lifting a corner of a puzzling phenomenon to see what underpins it. In this way, analytical questions help the researcher to investigate surprises in the data. Analytical questions stimulate finding connections, patterns, cases, principles, and ultimately new knowledge. Without these questions, the analysis would be little more than a review of what has been done within a study domain.

Use of analytical questions. Questions operationalize the guiding principles and range from broad to general to specific to precise (see Table 3-6). Initial broad questions (e.g., Why is the study of ethical sensitivity important to nursing? How is ethical sensitivity conceptualized in professional practice?) were based on study purpose. The initial analytical questions delimited the study's scope.

General questions (e.g., What are the preconditions, attributes, and outcomes of ethical sensitivity? When, where, and how is ethical sensitivity expressed?) encouraged sampling of the literature that offered the richest and clearest description of the concept. General questions facilitated identification of concept anatomy and physiology via use of two oppositional strategies: isolating concept dimensions (decontextualization) and interpreting concept meanings in context (recontextualization). Isolating permits

Table 3-6

Frame for Exploring Pragmatic Utility Using the Morse Criterion-Based Method

Principles	Analytical Processes of Critical Appraisal		
	Level of questions	**Criteria for questions**	**Examples of questions from exploration of ethical sensitivity**
Clarification of study purpose	Initial broad question to delimit scope/establish theoretical framework	Focus on content and significance of what can be known/gained from exploration of the concept within a circumscribed domain	Why is the study of ethical sensitivity important to nursing? How is ethical sensitivity conceptualized in the literature of nursing and other professional disciplines?
Validity	General questions to direct selecting and sorting literature to meet study needs (e.g., by disciplinary perspective and concept dimensions)	Use of two oppositional strategies: 1. Isolating concept dimensions/disciplines 2. Interpreting meaning in context	What are the preconditions, attributes, and outcomes of ethical sensitivity in each professional discipline? What other concepts are described with ethical sensitivity? When, where, with whom, and how is ethical sensitivity expressed?
Comprehen-sion of topic	Specific questions to assess concept maturity using criteria developed by Morse and her colleagues	Evaluation of degree of concept coherence with epistemological, logical, linguistic, and pragmatic principles individually and together	Are attributes, preconditions, and outcomes fully described? Is concept useful to the discipline? Does it fit with phenomena common to the discipline? Concept used consistently and appropriately within its context? Does it hold its boundaries through integration with other concepts?
Synthesis of results	Precise questions 1. Compare answers, identifying connections and patterns in knowledge of the concept. 2. Direct thinking outside the limits of the current state of knowledge.	Analytical questions to push beyond current knowledge of the concept	Is ethical sensitivity applied to all practice situations or just to particular ones? Is ethical sensitivity a futuristic/anticipatory concept or does it emerge only with here and now dilemmas?

recognition of the concept's universal properties. Interpreting meaning enables determination of the concept's capacity to inform professional practice.

Specific questions to comprehend the topic were structured around evaluation of concept maturity (e.g., Are attributes, preconditions, and outcomes fully described? Is the concept useful to the discipline? Does it fit with other phenomena? Is it used consistently within its context? Does it hold its boundaries through integration with others?) It is important to question maturity because differing connotations and meanings may have evolved over the course of the concept's use. Unless theoretical confusion is identified and the concept clearly comprehended, knowledge development will be impeded.

The broad, general, and specific questions are initial questions that help ensure an inductive approach to explore the emerging conceptualization. These questions require researchers to use subjectivity in responding to and interpreting the data and objectivity in letting the data reveal their gaps and perplexities. Initial questions provide flexibility, organization, and room within the methodological framework to explore concept components, function, and maturity. In contrast to initial questions, the precise analytical questions emerge while appraising concept maturity and direct concept development.

Criteria for analytical questions. Criteria were developed for assessing the adequacy of the analytical questions (see Table 3-7). Individual questions must describe what is needed with clarity (informatively, precisely, and concisely). They must help yield insights of disciplinary significance. They must encompass the depth and breadth of the concept. Although they emerge from and are driven by the data, they must stimulate "thinking outside the box" to enable transformation of data to higher levels of abstraction and explanation. Collectively, the analytical questions must be adequate to facilitate

Table 3-7

Criteria for Assessing Analytical Questions

I. Each question of the set of analytical questions is assessed individually for:

CLARITY
A question must precisely connote intent. *Is the question non-parasitical (not dependent on other questions)? Is it understandable to any and all readers? Does it orient readers to the type of answer expected? Does it have a single focus?*

SIGNIFICANCE
A question must pursue a significant line of inquiry within the substantive area and discipline to benefit research, science, and practice. It must maximize the current research opportunity for developing knowledge. *Does the question address important, non-trivial content in an area that needs development? Does it aid hypothesis formation or prediction? Does it promote insight?*

DEPTH
A question must be contoured to penetrate and reveal what is not obvious. It is not tailored in advance to yield expected answers. Depth involves using both broad and finely tuned questions. *Does the question dissect major controversy and reveal schools of thought? Does it surface accurate detail?*

BREADTH
A question must have wide range of application.
Is the question broad spectrum for "across the board" interdisciplinary synthesis? Does the question attend to special assumptions and restrictions of a single discipline?

DATA-DRIVEN YET DATA-TRANSFORMATIVE
A question must not be reductive but rather must unveil the concept. Meanings of the concept that are not pertinent to the study are not explored. Questions are persuasive to capture the underlying paradoxes, mysteries, and tangles within the concept.
Does the question fit with the phenomenon? Is it cogent? Is it illuminatory?

II. The set of analytical questions as a whole is assessed for:

COMPREHENSIVENESS
The questions must fully and completely cover the domain of the concept.
Are there other aspects about the concept that are not included by the questions?

COMPARISON
The questions must permit comparison, illuminate differences, contrasts, and variations.
Have the questions been formulated to elicit differences between and among the disciplines? Can the questions be answered by the literature of each discipline?

BALANCE
The questions as a set must not be targeted to one area but reflect a fair and comprehensive approach to the concept. All perspectives are treated respectfully and regarded as equally important.
Is there bias toward a particular disciplinary, theoretical, or author perspective? Is the question mindful of the "pink elephant syndrome" (i.e., seeing in the data what the researcher hoped to see from the beginning)?

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synthesis. They must comprehensively address the entire domain of the concept, illuminate differences across disciplines, and seek a balanced perspective.

Technique of asking analytic questions. The set of analytical questions used to explore the concept of ethical sensitivity comprised three areas: nature of ethical sensitivity, ethical requirements for praxis, and preparation for practice (see Table 3-8). These questions met the criteria specified in Table 3-7 for clarity, significance, depth, breadth, data-transformation, comprehensiveness, comparison, and balance. Questions to gauge significance were concerned with the futuristic or anticipatory function of ethical sensitivity, personal and interpersonal characteristics, and teaching strategies to prepare professionals to develop ethical sensitivity. The question about the nature of ethical sensitivity as innate or acquired was one of depth which requires theoretical underpinnings of contradictory and complementary schools of thinking to be surfaced. All the questions display breadth: they could be asked of all disciplines. Questions about applying ethical sensitivity in all versus particular practice situations and about the level of the professional's involvement have the greatest breadth. The questions about variations in types, the relationship between technical competency and ethical sensitivity, and the translation of ethical sensitivity into action were formulated to think outside of existing conceptualizations. All of the questions could be answered from the literature of each discipline permitting comparison across the disciplines. Balance was sought in looking at ethical sensitivity from an organization's perspective.

Analytical questions can be directly asked of all the literature. They penetrate the concept and allow synthesis of information. They employ two mechanisms. One is comparing incidents of data with others in same and different categories to expose

relationships. The other is a type of hypothesis working which enables the researcher to move between description and verification. This technique yields rich insight into the phenomenon represented by the concept.

Analytical questions allow breaking free of limited categorizations and conceptualizations to generate overarching themes, hypotheses, and conclusions about the concept. They push beyond surface responses and explicit assumptions to create new reasoning until categories are rounded out and saturated with incoming data.

Table 3-8

Analytical Questions Used in Concept Analysis of Ethical Sensitivity

Nature of Ethical Sensitivity
1. Is ethical sensitivity applied in all practice situations or just in particular ones?
2. Does ethical sensitivity have a futuristic or anticipatory function or does it emerge only within on-going dilemmas?
3. Are there variations in types of ethical sensitivity? Is ethical sensitivity graduated (e.g., continuum from low to high) or absolute (e.g., present or absent in particular situations)?
4. Does the nature of ethical sensitivity change with the level of the professional's involvement in the situation (e.g., if the professional is an observer or an actor in the setting)? Can a professional have ethical sensitivity if it does not translate into an action or behaviour?
5. Is ethical sensitivity innate or acquired?
6. What is the relationship between technical competency and ethical sensitivity (e.g., Must a professional be competent to be ethically sensitive? Can a professional be ethically sensitive without being competent? Could a physician be able to recognize ethical content in an accounting situation?)
Ethical requirements for praxis
7. What personal and interpersonal characteristics are required for developing ethical sensitivity in professional and interdisciplinary praxis?
8. Do employing organizations foster ethical sensitivity?
Preparation for Professional Practice
9. Assuming that ethical sensitivity or at least some aspect of it can be taught or learned, what if any strategies best prepare professionals to develop ethical sensitivity?

Results of asking analytical questions. Answers from asking analytical questions (1 – 8, Table 3-8) are summarized.

1. *Is ethical sensitivity applied to all practice situations or just in particular ones?* Ethical sensitivity is described both as a quality - like virtue or caring attitude - that professionals bring to all practice situations and as a way of attending to what is going on within a particular situation of uncertainty for which no clear guidelines are known in advance. Ethical sensitivity is not "mere acquiescence" (Steinkraus, 1987, p. 126)such as professionals merely performing the requirements of their jobs without responding to special needs of the client or situation.

2. *Does ethical sensitivity have a futuristic or anticipatory function or does it emerge only within on-going dilemmas?* Ethical sensitivity does not require a dilemma or conflict to exist because ethical sensitivity is more than problem solving, clarifying, and justifying (Ersoy & Gundogmus, 2003; Hebert, Meslin & Dunn, 1992). The association of ethical sensitivity with dilemmas is related to the initial dilemma-based instrument developed by Bebeau, Rest, and Yarmoor (1985) who considered available instruments to measure values of empathy, humanism, and cynicism to be too general for relevance to ethical sensitivity in a professional context. In measuring only dilemmas, the instrument fractured theoretical understanding of the concept from its measurement. Ethical sensitivity has a futuristic or collective good focus (Baron, 1991; Kuzel, Engel, Addison & Bogdewic, 1994), and is geared toward preventing harm to others and toward long term commitment (Bouley, 1984; Procario-Foley & McLaughlin, 2003; Robson, 2002; Schneyer, 1991).

3. *Are there variations in types of ethical sensitivity? Is ethical sensitivity graduated (e.g., continuum from low to high) or absolute (e.g., present or absent in particular situations)?* Ethical sensitivity is a uniform quality present or absent in particular situations. It is influenced by: (a) ability to focus away from self toward the client (May, 1992; Nortvedt, 2003; Simpson & Garrison, 1995), (b) characteristics of the situation (e.g., timing, type of involvement), and (c) characteristics of the professional including cognitive-perceptual, psychosocial, and moral development (Bebeau & Brabeck, 1989; Clarkeburn, 2002; Lind, 1997; Sherwin, 2001; Simpson & Garrison, 1995). Ethical sensitivity has been referred to as a process in degrees rather than as an "all or none" quality because its skill and knowledge components develop with practice and study so that over time the professional becomes more ethically sensitive (e.g., Baldwin & Bunch, 2000; Casarett, 1999; Punzo, 1996).

4. *Does the nature of ethical sensitivity change with the level of the professional's involvement in the situation (e.g., if the professional is an observer or an actor in the setting)? Can a professional have ethical sensitivity if it does not translate into an action or behaviour?* All attributes must be present for ethical sensitivity to be expressed. There can be no ethical sensitivity in either observer or participant role if the professional is not affected, perceptive, and conscious of client needs and the dynamics of the situation. Having a higher ethical sensitivity score as determined by available instruments does not imply that a person will act more ethically (Al-Kazemi & Zajac, 1999; Sparks & Hunt, 1998; Wittmer, 2000). This is because current measures for ethical sensitivity fail to capture its multidimensional complexity.

The nature of ethical sensitivity does not change with the level of professional involvement as actor or observer. Ethical sensitivity must be expressed behaviourally through judging and acting wisely and compassionately. Barriers to expressing ethical sensitivity through action may confront professionals in practice. Internal barriers include discomfort opposing other professionals (Schroeter, 1999), fear of litigation (Heilicser, 1997), reluctance to interfere in colleagues' work (Layman & McNamara, 1997), state of exhaustion (Holland, 1998), and belief that one cannot change oneself in substantive ways (Payne & Giacalone, 1990). External barriers include organizational policies and protocols that limit autonomy over professionals' decisions (Granstrom, 1995; Jaeger, 2001; Lutzen, 1990; Simpson & Garrison, 1995), uphold an "assembly line" approach to care (Heilicser, 1997), and do not offer preparation and guidance for professionals (Housman & Stake, 1999; Walker, 1991). These barriers may be perceived as insurmountable. However, professionals, who are aware of and affected by an issue but who do not act, lack ethical sensitivity.

5. *Is ethical sensitivity innate or acquired?* Authors from all disciplines hold the view of ethical sensitivity as to some extent acquired while no discipline supports the view of ethical sensitivity as exclusively innate despite research in psychology involving studies of Magnetic Resonance Imaging that show activation of different frontal cortex patterns when processing stimuli with moral content (Eslinger, 2002; Moll, de Oliveira-Souza & Eslinger, 2003) and clinical observations that report children as young as 9 months refusing to spank dolls (Silverman, 1994). The view of ethical sensitivity as both innate and acquired is supported by Weaver's (2005) finding that ethical sensitivity has a combined core of innately derived affect and acquired components of knowledge,

cognition, skill, and responsibility. According to authors in psychology, the cognitive-perceptual component of ethical sensitivity can be enhanced; for instance, a person who sees only one image in an ambiguous figure can be shown to see another (DesAutels, 1996; Kyte, 1996). Ethical sensitivity may also be modified by environmental interventions including professional socialization (Bebeau, Rest & Yamoor, 1985; Hebert et al., 1992; Lerman, 1998; Sparks & Hunt, 1998), psychotherapy (Lipson & Lipson, 1996), and general socialization and human evolution (Callahan, 2002; Smilansky, 1996).

6. *What is the relationship between professional technical competency and ethical sensitivity (e.g., Must a professional be competent to be ethically sensitive?* Ethical sensitivity and technical competency are different expectations of professionals. According to Aristotle (1962), technical (techne) is techniques applied, well or poorly, to reach a specific end or product. Thus technical is concerned with outcome. Ethical sensitivity involves consideration of the quality of the process of recognizing and appropriately responding to client need as well as its outcome of client comfort and well-being. Ethical sensitivity requires reflexivity on the part of the professional to determine role and commitment within a particular situation (Hawkins, 2001; Hepburn, 1993; Peerson & Yong, 2003; Punzo, 1996). The professional expresses ethical sensitivity in "not losing his or herself in technology and treatments and through authentic human presencing" (Gastmans, 1999, p. 219). Technical competency without ethical sensitivity may result in skills being used in an impersonal robotic or automatic way (Cook, 1999).

Can a professional be ethically sensitive without being competent? A professional cannot be ethically sensitive if not technically competent. Although technical is not usually seen as moral or ethical, it (technical) takes on a moral and ethical aspect when

professionals are involved in the lives of vulnerable human beings (Casarett, 1999; Johnson, 2001). Moreover, in the field of genetic engineering, ethical sensitivity has been construed as a tool for scrutinizing technical advances to uncover risks and disadvantages to humans and their relationships (Conway (2000).

Could a physician recognize ethical content in an accounting situation)? A view of ethical sensitivity as professional discipline-specific arose for two reasons. The first is that most instruments to measure ethical sensitivity, for example the Dental Ethical Sensitivity Test (Bebeau et al., 1985) and the Racial Ethical Sensitivity Test in education (Brabeck et al., 2000), are tied to the code of ethics of an individual professional discipline. The second reason is that research findings indicate that professionals, even those in related disciplines such as nursing and medicine, are sensitive to different aspects within the same care situation (Joudrey & Gough, 1999; Lutzen, Johansson & Nordstrom, 2000).

This view of ethical sensitivity as professional discipline-specific has been challenged. In medicine, Crowden (2003; 2004) has put forward a view of ethical sensitivity as interdisciplinary because members of related professional disciplines share a common ethic and are responsible for the same group of clients. Crowden's perspective is supported by accountants (Procario-Foley & McLaughlin, 2003) and nurse educators (Gastmans, 2002) who argue the need for complex ethical issues to be addressed by multiple expertise and knowledge. Ethical sensitivity is considered wider and more general than the clinical expertise of single professional discipline because it necessarily involves legal and economic discourses (Meulenbergs, Verpeet, Schotsmans & Gastmans, 2004). Authors critiquing codes of ethical conduct assert codes of ethics have

limited impact on ethical sensitivity (Dunbar, 1998; Winstanley & Woodall, 2000; Yetmar & Eastman, 2000). These authors agree that the knowledge of the values of a professional discipline contained in its codes is needed. However, blind adherence to abstract expectations for conduct does not foster ethical sensitivity (Meulenbergs et al., 2004).

Other authors say the character of the professional influences ethical sensitivity. Medical physicians and accountants may be guided by their sense of what it is to be moral, values, and attitudes influenced by experience and context (Conroy & Emerson, 2004; Crowden, 2003; McPhail, 2001). For example, experienced auditors were found to accurately identify fraud risk while inexperienced auditors required more contextual information to correctly judge fraud risk (Abdolmohammadi & Owhoso, 2000).

Ethical sensitivity is professional discipline-specific to the extent that it requires the knowledge of the agreed upon values of a professional discipline expressed in its code of ethics, is developed by experience, and is influenced by the context of professional practice. Ethical sensitivity is interdisciplinary in that complex issues require the input of diverse skills and sources of knowledge. Thus a physician may or may not be able to recognize the ethical content in an accounting situation.

7. *What personal and interpersonal characteristics are required for developing ethical sensitivity in professional and interdisciplinary praxis?* For a professional to begin to develop ethical sensitvity, the following are needed: respect (Hepburn, 1993; Niven & Scott, 2003; Payne & Giacalone, 1990; Raywid, 1986), otherness (Hawkins, 2001), and ego strength or being able to expose oneself to one's own and to another person's distress without the protection of distraction or denial (Niven & Scott, 2003).

Respect involves positive regard for others, tolerance of differences, and gentleness (Endo et al., 2000; Koh, 1999; Nortvedt, 2003; Schnitzer, 1996; Scott, 1995). Otherness requires curiosity to maintain interest in the viewpoints of others and to understand the fallibilities and blind spots of others and self (Branch, 2000; Green, 2004; Rosenfield & Jones, 2004). Also required are altruism (Robins, Braddock & Fryer-Edwards, 2002), perspective-taking (Brabeck et al., 2000; Garrod, 1989; Pratt & Norris, 1999), and ability to bracket one's own attachments to see differences of choice and vision (Kyte, 1996).

To recognize and interpret client needs, professionals are required to have cognitive-perceptual ability, a degree of scepticism, and propensity for learning. Cognitive-perceptual ability is influenced by conscience to judge past thoughts and actions and guide future decisions (Issler, 1993) and skill in appraisal and reappraisal (DesAutels, 1996; Fricker, 2003). Scepticism is needed to safeguard against being taken in by dominant mythology (Symonds, 1995). Professionals must commit to learning from clients and this commitment must be lifelong (Chaves, 2000; Rosenbaum, 2003).

To respond appropriately to clients, professionals need to develop characteristics of fellow-feeling, mental discipline, prudence, humility, ability to care for self, and commitment to ethical ideals. Fellow feeling consists of empathy, compassion, and sympathy (Blum, 1991; Issler, 1993; McNamee, 2002; Piper, 1991; Sieminska, Szymanska & Mausch, 2002). Mental discipline is achieved through perseverance (Holland, 1998; Tarlier, 2004) and fitness of character demonstrated in stability, adjusted personality, and responsible use of substances (Johnson & Campbell, 2002). Prudence or carefulness (Callahan, 2002) enables wise choices. Humility is needed to recognize limitations in one's own moral vision (Anderson & Hall, 1995; Callahan, 2002).

Professionals must perform adequate self care to be able to respond to others (Flannery, 1995). Commitment to ethical ideals including autonomy and justice (Myyry & Helkama, 2002), benevolence (Lutzen, 1990), and love for one's enemies (Bouley, 1984) is needed.

8. *Do organizations foster ethical sensitivity?* Organizations may deter rather than foster ethical sensitivity by: limiting the degree of autonomy over professionals' work responsibilities and decision-making, establishing philosophy and policies that contribute to neglect or violations of clients, controlling resources (e.g., time allotted, staffing mix, continuing education venues, and opportunities for participating in conflict resolution) (Jaeger, 2001; Leino-Kilpi et al., 2003; Lutzen, Cronqvist, Magnusson & Andersson, 2003; Niven & Scott, 2003; Schroeter, 1999). In the academic literature, cultures and societies as well as individuals and organizations are purported to be (or fail to be) ethically sensitive. For example, individuals from different cultures weigh risks associated with unethical practices differently (Teoh, Serang & Lim, 1999). No differences in ethical sensitivity scores between genders were found in settings dominated by written rules (Simga-Mugan & Onkal-Atay, 2003).

Synthesis of results of using analytical questions. A taxonomy of characteristics defining ethical sensitivity was constructed from synthesizing the answers to the analytical questions. The results clearly explicate preconditions, attributes, and outcomes and identify what and what is not ethical sensitivity (see Table 3.9).

Table 3-9

Taxonomy of Ethical Sensitivity Characteristics

Preconditions:	**Ethical Sensitivity**	**Not Ethical Sensitivity**
Suffering & vulnerability cues	ES triggered by watching suffering of others (Malone, 2000)	Moral blindness (Not see/ hear/detect cues) (Gastmans, (2002)
Uncertainty	Presence of moral doubt & dissonance (Hawkins, 2001; (McPhail, 2001) * Not know rules in advance * Situation of ambiguity - above & beyond technical competency * Sense of own vision as limited & that own beliefs may not hold true (Bracci, 2001; Georges, 2002; Scott, 2000; Walker, 1991)	Moral certainty * Knows in advance what is right to do (Wurzback, 1999) * Addresses situation as technical (Kane, 2003; Oddi et al., 1995; Shaner, 1989) * "Cognitive conservation" (seeks information consistent with own beliefs) (Payne & Giacalone, 1990)
Relationship	Engagement (Punzo, 1996; Sarat, 1991) Cooperative (Wallace et al., 1995), non-hierarchal (Canon, 1985; Keenan, 2002)	Detachment (Jaeger, 2001; Lerman, 1998; Mahone, 2000) * Autocratic, power-over (e.g., managed care) (Ulrich et al., 2003)
Receptivity	Open-mindedness toward possible ethical issues (Branch, 2000; Vetlesen, 1994)	Indifference (Nortvedt, 2001) "Survivalist" mentality (Shaner, 1989) False front/hard shell (Hueber, 1996)
Responsiveness	Feels responsible for impact of own actions or potential actions (Rest, 1982) Internal locus of control (Aharony & Geva, 2003) Internalized commitment to others	Insensitive of potential for harming others, nature, & environment (May, 1992) External locus of control (Aharony & Geva, 2003) Doing one's duty as externally prescribed (Steinkraus, 1987)
Courage	Acting consistently with own opinions (Mohr & Horton-Deutsch, 2001; Naden & Eriksson, 2004; Stark, 2001)	Passivity

Table 3-7 (Continued)

Taxonomy of Ethical Sensitivity Characteristics

Attributes:		
Moral Perception		
Awakening	Spontaneous (unassisted) recognition (Clarkeburn, 2002b; Simpson & Garrison, 1995)	Others must point out ethical problem
Particularizing	Accurate decoding of non-verbal cues (i.e., identifies components of discrimination, abuse, extreme pain, illness in situation) (Bebeau & Brabeck, 1989)	Incorrect recognition of ethical components (related to inexperience, emergency situation) (Abdolmohammadi & Owhoso, 2000;Narvaez, 1991)
Affectivity	In-touch with/protects own humanity & vulnerability (i.e., not a "robot") (Flannery, 1995)	Desensitized to own needs (i.e., "wounded healer" who lives vicariously through others) (Green, 2004)
Dividing Loyalties		
Interpretation	Inclusion of relevant others to gain broad view Interdisciplinarity (Crowden, 2003, 2004) Open public forums (Conway, 2000)	Exclusion or mere tolerance of relevant stakeholders Blind partiality or impartiality
Justification	Long term public commitment (Canon, 1992)	Short term private advantage (Procario-Foley & McLaughlin, 2003)
	Examines referent community values re the ethical principles being sustained (Canon, 1992)	May not consider referent community values. May ignore if sanctions not clear or enforceable
Reflexivity	Moral & developmental maturity	Lack of maturity Deception/moral hypocrisy (Batson et al., 1999; Kitchener, 1992)
	Commitments are "identity-conferring" (i.e., cannot live with self if break them) (McFall, 1987)	Commitments are "identity-defeasible" (may delegate to others) (McFall, 1987).
	Autonomy to influence quality of care (Yarling & McElmurry, 1986)	Limited autonomy (Granstrom, 1995; Huebner, 1996; Jaeger, 2001; Lutzen, 1990)

Table 3-7 (Continued)

Taxonomy of Ethical Sensitivity Characteristics

Outcomes:		
Client comfort & well-being	Client satisfied - feels heard and that issues matter to the professional (Sarat, 1991)	Client dissatisfied Moral neglect of client (Sherwin, 2001)
Professional learning & transcendence	"Becomes" ethically sensitive/noble (Flowers, 2001)	Unable to transfer skills to future/unfamiliar situations (requires on-going guidance & preparation)
	Practices appropriate self care (e.g., obtains support) (Layman & McNamara, 1997)	May practice self neglect (e.g. exhaustion) (Holland, 1998)
Integrity-Preserving Compromise (Benjamin, 1991)	Directs care to common good (Baron, 1991; Layman & McNamara, 1997; Simpson & Garrison, 1995), preventing harm (Robson, 2002; Scheyer, 1991), and global salvation (Bouley, 1984; Pawlikowski, 1984)	Ignores common welfare by placing individual/private over public/collective interest: (a) Pure "client" perspective (Bailey, 1999) (b) Self-interest (Canon, 1992; Garrod, 1989; Mudrack et al., 1999; Rest et al., 1997) Ignores client welfare (Banja, 1994; May, 1992; Symonds, 1995): (a) Routine-oriented care – Focus on profession, organization, or society

The above taxonomy provides a clear description of ethical sensitivity. To elaborate, the presence of suffering and vulnerability cues of clients, when observed by professionals may trigger the development of ethical sensitivity. This is because suffering, a universal condition (Bowden, 2000; Vetlesen, 1994), resonates with the observer. The discomfort of apprehending the client's suffering and vulnerability occurs within the context of uncertainty. The professional does not know what to do, what rules

to follow. The uncertainty must be maintained until the professional has an adequate understanding of the situation. The professional may strive to minimize the exposure to suffering and uncertainty via adopting moral blindness, indifference or a survivalist mentality, a hard shell or false front; attending to only technical aspects of care and service; or detaching. Professional-client relationships that are characterized by receptivity (open-mindedness), responsiveness (awareness of the impact of actual or potential actions on the other, inward commitment to client), and courage (acting in accordance with beliefs and feelings versus remaining passive) are required for the development of ethical sensitivity.

Attributes of moral perception (detecting and interpreting client cues), affectivity (embodied response of the professional to the client and the client's plight), and dividing loyalties (choosing how to address the needs of the client and relevant stakeholders) enable the professional to formulate an appropriate response for the situation. Moral perception consists of awakening (spontaneous recognition of the ethical demand without prompting) and particularizing (accurate decoding of cues in the situation). Affectivity involves the professional struggling to keep in touch with own humanity and vulnerability while being affected by the client's struggle. Professionals who desensitize to and do not appropriately manage their self care needs (i.e., wounded healers) are poorly prepared to respond to the suffering and vulnerability of others. The client may thus experience moral neglect. Professionals engage in three strategies of dividing loyalties to fully comprehend and decide what if any action they will take: interpretation of all relevant perspectives, justification, and reflexivity. Justification occurs through examination of referent community values regarding the ethical principles being

sustained in the situation and comparison of short-term private advantage against long-term public commitment. Reflexivity enables professionals to identify what they will ultimately do to influence the quality of care.

Outcomes of client comfort and well-being are associated with client satisfaction. In responding with ethical sensitivity to the situation, the professional experiences learning and transcendence (capacity for transforming old view of self, others, and situations) which, in turn, facilitates ability to respond to similar situations with enhanced ethical sensitivity. Through integrity-preserving compromise (Benjamin, 1991), professionals direct care toward a common good or global salvation rather than seeing things from "pure client", self interest, or organizational perspectives.

Contribution of Analytical Questions

Analytical questions benefit the research project by eliciting implicit and explicit answers to puzzles from the literature. They enabled a taxonomy of essential characteristics of ethical sensitivity to be derived from an interdisciplinary perspective. Analytical questions promote the scientific and intellectual rigor of the method by enhancing validity, data adequacy, depth of analysis, development of argument, level of abstractness, and contribution to knowledge.

Rigor. Validity was ensured through following sample inclusion criteria to access adequate, appropriate literature and preventing bias in not limiting the literature to a single discipline. The sample consisted of a diverse set of articles, chapters, and books relevant to the concept of ethical sensitivity.[d] The sample was adequate because it provided a picture of ethical sensitivity that was rich and detailed with categories saturated by replication of data. Depth of analysis was achieved through synthesized

[d] See Appendix C for a list of the citations used for the study of ethical sensitivity.

results of applications of the concept that exceeded current knowledge about ethical sensitivity, thereby contributing unique information to meet disciplinary needs.

The argument for studying the concept of ethical sensitivity in professional practice was grounded in the findings of previous qualitative inquiry and preliminary review of the adequacy of the current state of knowledge about the concept. The analytical questions stimulated logical, creative, and original results. Concurrent data collection and analysis ensured the research design adapted to the evolving understanding. The resulting conceptualization exhibited abstractness by its ability to consistently demonstrate the concept in all the forms in which it was manifested throughout various contexts.

The results (i.e., the taxonomy) have intuitive and logical grasp. They resonate with the expectations of professional practice. The concept analysis further contributed new areas of investigation by identifying empirical questions to better understand the multidimensional nature of the phenomenon of ethical sensitivity, its preconditions and outcomes. The findings elucidated the futuristic role of ethical sensitivity in preventing ethical problems, and the role of organizations in influencing ethical sensitivity.

Benefits to research and nursing. Using analytical questions added transparency to the research process. It enhanced credibility because both the questions and published literature are available to others who may use the findings. The results from using the analytical questions of the Criterion-based method prepared a strong scientific foundation into which questions and findings of future research may be positioned.

Limitations

The use of analytical questions is complex and demanding - questions and conceptualizations do not "emerge" on their own or by the researcher adhering to a set of easy to follow steps. Asking analytical questions requires a high level of scholarly discipline to comprehend, analyze, and synthesize literature about the concept. It involves profound understanding of the topic based on extensive search of relevant literature, sustained curiosity about aspects of the concept that need clarification, and ability to recognize and synthesize new insights from on-going analytical processing of incoming data. A limitation of the method is the lack of a detailed resource manual.

Another limitation is the "glass ceiling" effect. This means that advancement of science using analytical questions formulated from the literature cannot exceed the level of development of the disciplinary knowledge base. Inability to answer questions because literature is not available indicates the need to acquire a different type of data through a different method (e.g., interview, observation) to serve study purpose.

Asking analytical questions as a strategy of critical appraisal may be confused with literature review and secondary analysis. Critical appraisal differs from review of the literature in disciplinary usefulness and rigor. Critical appraisal is active inquiry that enables exploration of assumptions underlying conceptualizations of concepts within research programs and guides concept development (Morse, 2000). Literature review is less active summarizing of all or selected research concerning a particular topic that may be a part, but not the major component, of a research project. In the ethical sensitivity project, review of the literature helped to (a) identify allied concepts competing with the concept of ethical sensitivity to explain the phenomenon, (b) enable identification of

confusing areas (e.g., the complex nature of ethical sensitivity, differences in its measurement, and conflicting strategies about its teaching and learning), and (c) establish a baseline level of knowledge about ethical sensitivity. The results from critical appraisal using analytical questions provided clarification of theoretical confusion. Unlike the literature review, critical appraisal resulted in attainment of new knowledge within well-defined criteria for scientific rigor.

Secondary analysis of data "makes use of pre-existing quantitative or qualitative data for the purposes of investigating new questions or verifying previous studies" (Heaton, 2004, p. 16). The technique of asking analytical questions within the Morse Criterion-based method roughly fits this definition. However, secondary analysis as a research method uses data that are part of recognizable data sets rather than individual isolated research projects. Asking analytical questions involves recruiting previously ungrouped disciplinary literature as data into the inquiry. In other words, asking analytical questions frees inquiry from pre-existing conceptualizations and boundaries.

Conclusions

Asking analytical questions, a strategy of the Morse Criterion-based method for concept analysis, is challenging because initially researchers do not know what to ask. They must immerse themselves in the data to develop understanding of what is being studied before they can derive questions to enable synthesis.

Analytical questions are a necessary stimulus to inquiry. They help reveal knowledge about the concept that was hitherto unnoticed. They are formulated to aid understanding aspects of the concept that are incomplete or confusing, and aspects that may have been uncritically addressed and accepted by members of professional

disciplines. The answers researchers get to analytical questions depend on the construction of the question and the level of science available to answer the question. Analytical questions engage researchers in ever-widening circles of vertical and lateral thinking, analysis, and synthesis beyond the limits of isolated studies and individual disciplines. Analytical questions are necessarily substantial, interesting, and actively contribute to the knowledge of the concept rather than passively request information from the literature. Asking analytical questions is neither a one-time nor a short-term exercise but rather a long-term commitment to disciplinary and interdisciplinary development.

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Chapter 4

WHAT IS ETHICAL SENSITIVITY? ANALYSIS OF THE CONCEPT AS DISCOVERED IN THE LITERATURE

Ethical sensitivity is the means through which nurses and other professionals recognize, interpret, and respond to the concerns of those receiving professional care and services, thus it is integral to clinical decision-making and the provision of excellent care. In his germinal work, Rest (1982) described the concept as moral sensitivity or "interpreting a situation by perceiving the potential influence of one's actions on the welfare of others" (p. 31). In 1985, with colleagues Bebeau and Yamoor, Rest chose the term ethical sensitivity "as distinguished from all things moral" (p. 227) since the actions of professionals are governed by codes of professional conduct. Since the introduction of the concept to science, various researchers in all professional disciplines[1] have studied ethical sensitivity. This abundance of literature has extended from Rest (1982) to theoretical divergence.

In this article, knowledge about ethical sensitivity is clarified and the utility of the concept to research and practice is enhanced. The concept required clarification because it was described in multiple ways (e.g., as a caring response, a skill in identifying ethical dimensions of care, an intuition regarding other's comfort and well-being, and a component of moral care). The Criterion-based method of concept analysis developed by Morse (1995; 2000) was used to explore ethical sensitivity and depict its dimensions. The research involved: examining conceptualizations of ethical sensitivity in nursing and other disciplines; asking questions of the literatures to identify and clarify the

[1] Professional disciplines are specialized branches of knowledge, each with a unique perspective for viewing and constructing knowledge about its phenomena of interest (Donaldson & Crowley, 1997/1978).

preconditions, essential attributes, boundaries, and outcomes of the concept; and synthesizing multiple meanings to achieve a consolidated definition. The findings offer researchers and practitioners an inclusive view of ethical sensitivity that transcends limitations in available conceptualizations.

Literature Reviewed

Review of the literatures of nursing and other professional disciplines revealed gaps and inconsistencies in knowledge about the concept of ethical sensitivity, diverse conceptualizations, and the need for rigorous qualitative inquiry (Weaver, 2005a). Multiple theoretical descriptors for ethical sensitivity portrayed only parts of the whole concept. For instance, Rest (1982) constructed ethical sensitivity as affect that activates cognitive processing. Researchers in business management and journalism (e.g., Bone & Corey, 2000; Potter, 1996) described ethical sensitivity as responsibility. Nursing inquiry, both qualitative (e.g., Lutzen, 1990; 1993) and philosophical (e.g., Nortvedt, 1998, 2001, 2003), have identified ethical sensitivity as combinations of the components of affect, cognition, skill, knowledge, and responsibility. However, relationships between the components have not been explicated. The concept was determined to be emerging in its evolution, partially mature in its development, and low-level with regard to scope and abstractness (Weaver, 2005a).

The use of different conceptualizations for ethical sensitivity within and across disciplines has reduced ability to integrate findings. Problematic areas in knowledge of the concept have included uncritical acceptance of ethical sensitivity as a positive quality without examination of its negative consequences (e.g., emotional overload, exploitation, and personal and moral distress), lack of scientific evaluation of educational interventions

to develop ethical sensitivity, and inadequate identification of the relationship between ethical sensitivity and agency. The use of convenience samples, underreporting of response rates and reliability and validity measures, and scant descriptions of theoretical frameworks have impaired rigor. Other methodological problems have involved nearly exclusive use of students as study respondents in some disciplines, researcher cuing of respondents to the presence of an ethical problem, employment of different measures for ethical sensitivity (e.g., attitude questionnaires, problem identification, and ranking the significance of ethical issues), and inconsistent use of standard distributions with which to compare raw scores (Weaver, 2005a). The differences in the quality of the studies have limited concept comprehension and disciplinary knowledge development. A rigorous qualitatively-driven method for concept analysis was deemed appropriate for enhancing utility of ethical sensitivity to research, science, education, and practice.

Morse Criterion-Based Method

Inquiry was situated within the postmodern, critical social theory tradition, enabling subjectivity and understanding of professional role as immediate, discursive interactions. The Morse Criterion-based method (2000) for exploring the pragmatic utility or usefulness of a concept to a discipline was the method of choice because the method was developed to analyze partially mature concepts, such as ethical sensitivity, for which an adequate body of literature was accessible. The method involved clarification of study purpose, examination of all relevant literature about the concept, attainment of concept comprehension, and asking analytical questions to synthesize results. The research and theoretical literatures of health and other professional disciplines were used as data.

To address the initial question: "How is ethical sensitivity conceptualized in nursing and other professional practice?" articles were located via on-going manual searching and computer searching of on-line professional data bases (e.g., CINAHL, Medline) using the search term *(ethic$ or moral$ or clinical) and (sensitiv$ or percept$ or sensib$ or intuit$) .ti,ab.*, the author search option, and manual searching. Inclusion criteria considered accessibility, relevancy (i.e., must contain an explicit or inferred definition of ethical sensitivity), and usefulness to the emerging conceptualization. The resultant sample consisted of 200 articles from the following fields: health care disciplines of nursing (47), medicine (19), psychology (28), dentistry (5), and bioethics (12); related caring disciplines of theology (9) and education (11); disciplines safeguarding public/private security, rights, and information: law (7), accounting or business (15), and journalism (8); and the more global disciplines of philosophy (21), political and social sciences (10), and women's studies (8). The sample was sorted by discipline and by conceptual dimensions. Data collection and analysis were concurrent. Themes identified within categories were compared with each other and with incoming data from the literature. Answers to analytical questions formulated from comprehension of the literature, provided new insights and knowledge. Scientific rigor has been reported elsewhere (Weaver, 2005b).

Findings

The anatomy or internal structure of the concept of ethical sensitivity was explored by isolating its components (decontextualizing). Physiology or action was investigated through interpreting the meaning of applications of the concept in various contexts (recontextualizing) of nursing and other professional disciplines. The process of

exploring the anatomy and physiology of the concept of ethical sensitivity is reported elsewhere (Weaver, 2005b). A model depicting relationships between concept dimensions has been developed (see Figure 4-1).

Overview of Ethical Sensitivity

Figure 4-1 conveys that within the context of uncertainty amid professional practice, *professional characteristics* of *receptivity*, *responsiveness*, and *courage* enable the professional to enter into relationships with the client[2] to respond to *client characteristics* of *suffering and vulnerability cues*. Through *awakening*, *particularizing*, and *affectivity*, the professional recognizes and responds to the plight of the client. The professional engages in a process of *dividing loyalties* which involves *interpreting* the perspectives of the client and those most affected, *justifying* approaches to meeting the client needs, and *reflexivity* to determine her/his role in the situation. The professional attempts to *preserve the integrity* of various stakeholders in deciding the appropriate balance of client or *person-led* versus *routine-oriented care* the situation requires. In the realm of person-led care, the client may express *satisfaction* and *reciprocate* through caring responses to the professional. However, when care is consistently based on following routines, the professional may experience *moral distress* and leave the profession. Outcomes of ethical sensitivity are *client comfort* and *professional learning*. This learning on the part of the professional allows the professional to *transcend* old views of self, the client, and the situation. Ethical sensitivity is a resource, a type of *practical wisdom* that the professional brings to practice as well as a quality that the professional develops through acting with ethical sensitivity.

[2] The term "client" refers to a person or persons receiving care and services from professionals. The term "patient" may be used when referring to client in health care contexts.

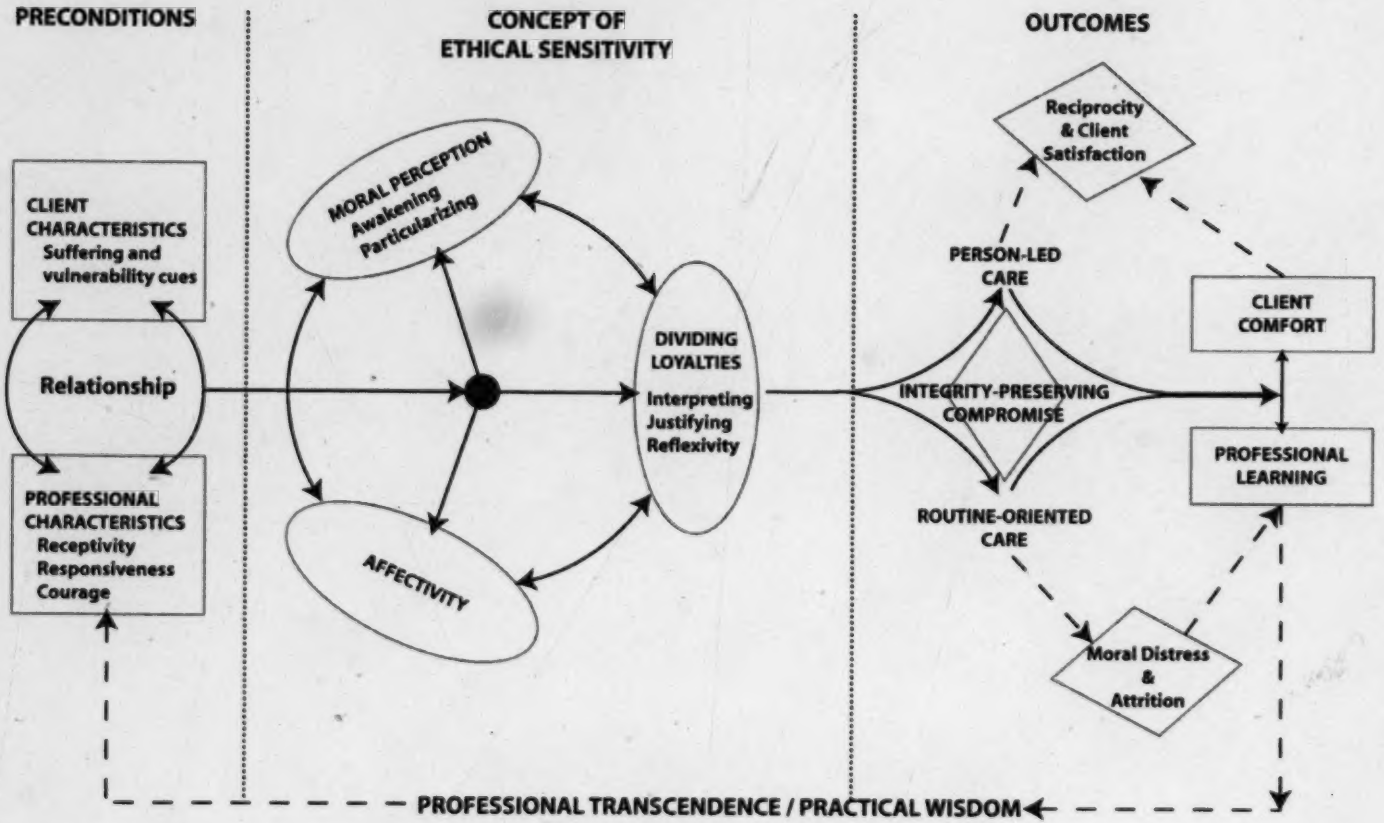

Figure 4-1. Conceptualization of Ethical Sensitivity.

Anatomy of the Concept of Ethical Sensitivity

Anatomy was analyzed by examining the following components: definitions, preconditions (antecedents), attributes (characteristics), boundaries (uniqueness), and outcomes (consequences).

Definition

The literatures revealed lack of consensus of definitions for ethical sensitivity both within and across professional disciplines (see Table 4-1). From these discipline-specific definitions, five defining aspects of ethical sensitivity were identified. First, it is an affective aspect of caring oriented toward excellence and compassion and values of altruism, tolerance, and public-mindedness. Second, it is a component of decision-making that involves perceiving, interpreting, and evaluating the ethical import of a situation. Third, it is skill development in relational interaction and character. Fourth, ethical sensitivity is a means for gaining more complete understanding of a particular situation through soliciting input from other perspectives including those of relevant stakeholders and knowledge from academic, clinical, and ethical theories. Fifth, ethical sensitivity is obligation that precedes and encompasses responsible agency. The following consolidated definition of ethical sensitivity in professional practice is proposed: *Ethical sensitivity is the capacity to decide and act wisely and compassionately within the uncertainty of a given care situation that draws on a critical understanding of codes for ethical conduct, clinical experience, academic learning, and self knowledge; it also includes the ability to anticipate the consequences of decisions and rests on courage.*

Table 4-1

Discipline-Specific Findings for Defining Ethical Sensitivity in Professional Practice

Discipline	Definitions
Nursing	Aspect of caring Characteristic of excellence in practice
Medicine	Characteristic of a virtuous practitioner similar to altruism and compassion Problem identification
Psychology	Affective response to other's needs Skill in detecting unethical behaviours
Dentistry	Recognition of special characteristics of patients and awareness of actions that affect the rights and welfare of others
Bioethics	Expanded scope of a situation based on inclusion and interpretation of other perspectives
Education	Relational quality of a teacher Professional tolerance
Theology	Obligation toward others, nature, and environment Individual decision (based on moral principles) to alleviate other's suffering
Accounting & Business	Expectation for professional practice Recognition of and ascription of value to the ethical dimension in a particular situation Quality of professionals that clients may evaluate
Law	Attitude about what is ethical Sources of knowledge that influence decision-making Spontaneous perception (intuition) of an ethical issue rather than having it pointed out
Journalism	Value of public or community spiritedness Client (audience) trait influencing reactions to TV and radio programs
Philosophy	Perception that goes beyond first impression of a situation Awareness and vigilance of the potential for acting to harm others
Social Sciences & Women's Studies	Evaluating and looking beyond the biases, experiences, assumptions, methods, and claims of the status quo

Preconditions

Ethical sensitivity in professional practice requires a context of uncertainty on the part of the professional and exposure to suffering and vulnerability cues of clients. Relationships between professionals and clients must be characterized by receptivity, responsiveness, and courage.

Uncertainty

Ethical sensitivity involves responding to the ethical demand of clients within situations that lack rules and clear criteria for their application. It is not based on a foundation of certainty but rather it requires that the professional's sense of certainty be disturbed (Hawkins, 2001; McPhail, 2001). Moral certainty is conviction that one knows what is right to do and willingness to act based on this conviction (Wurzbach, 1999). With moral certainty, one has no doubts or qualms, no need to discuss the situation, and no questioning of beliefs. Professional practice, however, involves situations of doubt as to what is right or best to do. There is no guarantee of an appropriate outcome as one can be mistaken. Ethical sensitivity is needed to grasp what is "mutable, indeterminate, and vague" (Simpson & Garrison, 1995, para 1). Professionals must look carefully to everything because they can never see all of reality (Georges, 2002; Scott, 2000; Walker, 1991). They must risk the uncertainty of not knowing what they will believe at the end of any encounter (Bracci, 2001). Uncertainty impels them to seek other viewpoints and to gain understanding of client cues and of own fallibilities, wounds, and blind spots (Branch, 2000; Rosenfield & Jones, 2004). Without challenging background convictions, ethical sensitivity will be absent and neglect of vulnerable stakeholders may occur (Sherwin, 2001).

Suffering and Vulnerability Cues

Cues are client responses of suffering and vulnerability related to actual and potential injuries or deficits associated with situational, developmental, and illness events (Nortvedt, 1993; Sanders, 1992). These cues are the object of professional attention because they connote universal need that resides in everyone (Bowden, 2000; Nortvedt, 2001). Because the illness and suffering of clients diminish ability to attract the attention of professionals (Niven & Scott, 2003), cues require surveillance on the professional's part. Length of exposure to the cues influences the professional's ability to discern the plight and needs of clients. For example, nurses initially become more sensitive to the needs of disabled patients and their families by spending time with them (Fox & Wilson, 1999). Longstanding exposure to cues blocks appreciation of the other's experience and may thereby decrease sensitivity (May, 1992). Severinsson (2003) found exposure to suffering cues so affected one nurse that she stopped identifying client needs to prevent emotional overload. Nurses lose sensitivity to cues about degree of pain and need for analgesics experienced by patients (Kelly, 1998; Stevens, Johnston & Grunau, 1995).

Relationship of Engagement

Ethical sensitivity requires engagement between professionals and clients (Punzo, 1996; Sarat, 1991). This personal connection enables the unique, irreplaceable, and one-time only characteristics of persons to be recognized (Simpson & Garrison, 1995). Indifference to the specific concerns of those receiving care and services results without such relationships (Nortvedt, 2001; Vetlesen, 1994). Relationships that are cooperative rather than competitive (Miller, Bredemeier & Shields, 1997) and egalitarian rather than oppressive (Sherwin, 2001) promote ethical sensitivity. For writer Hurston to access local

folklore narratives, she learned to "stand in solidarity," letting go of any hierarchical stance that could threaten the tale tellers (Cannon, 1985, p. 45). Ethical sensitivity is negatively correlated with power distance, the influence of one member over another in the relationship (e.g., supervisor over subordinates) and the extent to which individuals in a society accept unequally shared power as normal (Blodgett, Lu, Rose & Vitell, 2001; Keenan, 2002).

Four levels of relationship are micro, meso, macro, and global. The micro level, between clients and professionals, is influenced by professional codes defining professional boundaries and organizational culture. The distribution of resources within institutions may reduce time available for professionals to pick up cues and spend with clients (Kane, 2003; Niven & Scott, 2003). The meso level concerns relationships between the profession, organization, and society (e.g., the social responsibilities of the profession and organization). The macro level conveys the moral legitimacy of larger systems (e.g., socialism, capitalism). At the global level, attaining world community and preventing large scale evils (e.g., nuclear holocaust) are sought. The levels interact. For example, without a strong moral society, relationship at the micro level of professional – client interactions is hard to maintain (Pawlikowski, 1984; Rossouw, 1994).

Receptivity

Receptivity is openness to learning from others (Branch, 2000; Hawkins, 2001). Through a process of "unselfing," one's own sense of self is diminished to enable awareness of the other (Murdock, 1970, p. 84). Receptivity requires suspending judgment to prevent premature latching onto inadequate or faulty ideas (Granstrom, 1995; Holland, 1998). It creates opportunities to "tune in to" the other (Vetlesen, 1994, p. 205).

"welcome" the other's hurt, joy, and human experiences (Nortvedt, 2001, p. 34), and "clear the path" for being touched and concerned by the other (Gastmans, 2002, p. 497). It is focussing attention on what is happening to a particular person in a specific context (Punzo, 1996).

Receptivity is influenced by the adequacy of sensory receptors (Lind, 1997; Narvaez, 1991), availability of free "mind space" to receive the other amid competing obligations and bias (Oddi, Cassidy & Fisher, 1995), interest in the other (Vetlesen, 1994; Walker, 1991), and prevailing opinions surrounding an issue (Flannery, 1995; Gillett, 1994; Post, 1995). Receptivity may be impeded by emotions toward the individual in need (Narvaez, 1991). Professionals may "wall off" feelings (Malone, 2000, p. 7), concentrate on tasks (Georges, 2002), and erect a "hard shell" (Huebner, 1996, p. 267). Institutional practices such as standardized approaches to assessment narrow receptivity to that which has been externally predetermined (Higgins-D'Alessandro, 2002; Simpson & Garrison, 1995). Professionals may ignore indicators not readily "ticked off" on a list (Benjamin, 1991; Niven & Scott, 2003).

Responsiveness

Responsiveness is nonoptional obligation arising from being addressed by the demand of another's suffering or vulnerability (Bauman, 1994; Olthuis, 1997) or the anticipation of "potentially disastrous consequences of the exercise of human technological powers" (Mitcham, 1987, p. 26). It is based on understanding how one would feel in the other's place (Introna, 2002). These feelings are transformed into obligations to help clients meet specific needs (Branch, 2000). Responsiveness presupposes an internal locus of control; the professional responds not from duty alone

but from commitment to obligations and social responsibilities internalized as individual norms, and conviction that a certain response is required. Responsiveness differs from responsibility in that responsibility is imposed by the sanctions of others (e.g., institution, profession, religion, society) and accepted by the professional (Miller, Bersoff & Harwood, 1990; Patterson, 2001). Responsiveness is influenced by prevailing sociopolitical structures such as laws governing human rights (Banja & Banes, 1993; Flannery, 1995), institutional regulations (Diegmeuller, 1994), and professional practice legislation and codes for conduct (Dunbar, 1998). Autonomy or the freedom of professionals to think and act independently of institutions influences responsiveness. Autonomy is enhanced by support from colleagues and organizations (Cherrington, 2002; Gastmans, 2002).

Courage

Courage is the vital force of acting consistently with one's opinions (Simpson & Weiner, 1996, p. 350). It has been described as being "not afraid to use myself . . . and I enter into interpersonal relationships. . . [and] situations that may be difficult" (Naden & Eriksson, 2004, p. 87). Courage combines affect and skill to sustain "clear vision" (Murdock, 1970, p. 89) and other-focused purpose; for example, "I don't let that [doctors laughing because I take concerns to the head nurse] stop me. Otherwise, it's the patient that suffers" (Naden & Eriksson, 2004, p. 88). Courage involves feeling both fear and confidence as appropriate for a situation and fully realizing any harm and cost to self related to taking action (Stark, 2001). Courage is capacity to overcome fear to face moral challenges and do what is morally right (Mohr & Horton-Deutsch, 2001). Courage is a choice. The courageous person must assume full responsibility for the consequences of

acting when something of value is at stake. The person sees all the morally salient aspects of the situation (e.g., the danger, need for protection), assesses the strengths and weakness of the stakeholders involved including own interests, and chooses to act or not (Stark, 2001). Courage is needed to go against the flow (Canon, 1992), to challenge fixed conceptions of responsibility and normality (Connolly, 1993), and to risk placing cherished values in tension with one another (Bracci, 2001).

Attributes of the Concept of Ethical Sensitivity

In the following section, the attributes (essential characteristics) of ethical sensitivity: moral perception, affectivity, and dividing loyalties are described in detail. These attributes are composed of dimensions of cognition, affect, and knowledge. The knowledge dimension includes values, experience, academic, and clinical. The attributes enable professionals to understand the client situation and to make decisions regarding professional role.

Moral Perception

Moral perception is intuitive discrimination of cues and patterns that enable direct perception of client needs and gestalt recognition of the morality of the situation. Moral perception consists of dimensions of *awakening* and *particularizing*.

Awakening. Awakening is the beginning of awareness of the ethical nature of a problem that could negatively influence client well-being. Awakening relies on something outside of theoretical and self-referential knowledge. A professional goes about the technical aspects of practice in "sheer uncritical reflectiveness" (Fricker, 2003) or "prereflective consciousness" (Nortvedt, 2003) until interrupted by some cue.

Awakening is experienced as an intrusive gut level response akin to worry or alarm (May, 1992; Nortvedt, 1993), "a jolt" (Hawkins, 2001, p. 421) or "quickening" (Bergum, 1996, p. 8). It may originate during an actual encounter or retrospectively. It may be limited to initial immediacy. For instance, Arab found that an exposition of insider trading "wake[s] up" people for only a short time before they go "back to sleep in terms of ethical sensitivity" (Arab, 2001, para 11).

Upon awakening, the professional attempts to read the context to develop more informed understanding of the source and magnitude of the problem (Loye, 1993). Cues are tracked in terms of their orientation to space, time, and known objects or experiences (Sieminska, Szymanska & Mausch, 2002). Awakening is influenced by professional socialization to values of right and good that guide the professional to see the client interests in the situation (Lutzen, Nordin & Brolin, 1994; Sieminska et al., 2002).

Particularizing. Recognizing the particular ethical concern in a practice situation involves perceptual processing of the suffering and vulnerability cues. Perceptual processes may include: (a) feature detection (recognizing enough properties to classify some thing as a member of a type or kind), (b) task-guided abstraction (paying attention to various features of an object, event, or situation), (c) high level perceptual processing (drawing meaning out of a situation by making analogies and configuring data to provide an appropriate representation for a given context), and (d) conceptual deployment (using a conceptual framework developed from another experience or comprehension to understand a new situation) (DesAutels, 1996).

Particularizing is influenced by clarity of cues, availability of resources, and individual differences in motivation, maturity, and experience. Reduced amount and

clarity of cues (e.g. presence of dusk) creates ambiguity (Narvaez, 1991; Taborda & Arboleda-Florez, 1999). Initial confusion to a novel situation resolves with background knowledge or collateral information (Churchland, 1996). The availability of time and energy affects discernment of relevant facts (e.g., an emergency situation must be quickly assessed while an everyday dilemma may take longer) (Narvaez, 1991). Individuals differ in their social cognition (e.g., perspective taking, naming emotions and situations, and empathy), ego processing (e.g. styles of defensiveness and coping), human physiology (e.g., working memory limitations), and values and reasoning (Payne & Giacalone, 1990; Rest, 1982; Schnitzer, 1996; Sieminska et al., 2002). Accurate recognition of the situation's ethical demand is influenced by internalization of conceptual categories or prototypes (Keekes, 1984; Mehl, 1995) and experience (Abdolmohammadi & Owhoso, 2000; Lutzen, Evertzon & Nordin, 1997). Older adults may collaborate with others to compensate for cognitive limitations (Pratt & Norris, 1999).

Affectivity

Affectivity is spontaneous, embodied response to the other. It is described as feeling "shaken" (Nortvedt, 2003, p. 226) or "struck by the other's agony" (Nortvedt, 1998, p. 387), "seized" as hostage (Introna, 2002, p. 76), or pain from "grasp[ing] a hot poker" (May, 1992, p. 11). Affectivity is not factual calculation of costs and rewards – it is feeling the client's distress (Benner, 2004; Punzo, 1996). In being affected, professionals connect with their own vulnerabilities and are able to grasp what actually or potentially hurts the client. This prevents blindness and hard heartedness to the client's plight. It preserves client dignity and the social value of caring for clients (Malone, 2000).

Affectivity consists of inseparable affective and cognitive components: To cognitively understand an incident as painful or shocking necessitates being affectively moved (Nortvedt, 1998). The affective component is the response felt upon encountering the client's pain, suffering, or worry. It is "agonizing to bear witness to suffering. . . Suffering is not invisible. Clinicians watch . . . until they can no longer bear to watch" (Malone, 2000, p. 9). The cognitive component is activated by the affective component (Lutzen, Johansson & Nordstrom, 2000). To understand client pain as suffering involves interpreting it as agony and lived reality.

Affectivity is influenced by affective-biochemical responses and preconceived understanding of what it is to have been in similar discomfort (Narvaez, 1991). Walker (1991) asks: Could a person incapable of particular emotions and interests express ethical sensitivity? The answer is no. Emotions enable access to the moral domain of another because they pinpoint the salient cues and help to register and record facts with resonance and depth (Rest, 1982; Vetlesen, 1994). Professionals who can feel the affective responses of their clients can use these feelings to gain information about the moral conditions clients experience (Benner & Wrubel, 2001; Gastmans, 2002; Huebner, 1996). Professionals not in touch with personal fallibility, gut reactions, and values are "wounded healers" who may try to address their own unexamined issues through working with clients (Green, 2004).

Dividing Loyalties

Dividing loyalties is considering the situation from the perspective of the client, the professional and other stakeholders to determine if a moral decision must be made. Dividing loyalties is conscious cognitive processing of an event through strategies of interpretation, justification and reflexivity.

Interpretation. To interpret means to translate contextually. Interpretation enables full grasp of what is going on in a situation to authenticate or contradict moral perception (Thornton, 1999). Interpretation involves learning the perspectives of those most affected (e.g., client. self, administrators, stockholders, creditors, suppliers, colleagues, competitors), especially those who are disadvantaged, oppressed, or marginalized (Blodgett et al., 2001; Sherwin, 2001). Interpretation may involve dialogue between clients and professionals to explore divergence between what is happening and what should be happening in the situation (Lerman, 1998). Interpretation can be expanded beyond the current situation by examining historical texts (Conway, 2000) and considering the view points of other clients in the system and others regarded as experts both inside and outside the circle of the situation (Gillett, 1994; Sarat, 1991). Critical scrutiny of the larger social system may expose taken for granted assumptions and positions of privilege that have suppressed understanding (Conway, 2000; Ryu, 2001).

Interpretation is influenced by language because it is through language that professionals clarify concerns with clients. Professional use of technical language may impede client expression of concerns (Benner, 2004). Language hides or expresses emotions, altering awareness of self and situation by clients and professionals (Huebner, 1996; McNamee, 2002). For example, lack of language to describe characteristics and

needs of pupils limited teacher ability to participate in decision-making regarding complex pupil welfare problems (Granstrom, 1995).

Justification. Justification is comparing the demands of the particular situation against external standards (i.e., ethical and organizational theories, principles, and rules) to determine legitimacy. Immediate and long-term consequences to clients, professions, society, and global human solidarity are considered (Schneyer, 1991; Steinkraus, 1987). Possible options for meeting ethical demands are created and evaluated using moral imagination and choice. Moral imagination is used to identify a range of possible and desirable options for meeting client need (Scott, 2000; Simpson & Garrison, 1995). Choice involves being aware of moral categories and ethical principles, and evaluating their importance to the situation (Ersoy & Gundogmus, 2003) and to the needs and interests of each stakeholder (Thornton, 1999). In health care, justification may require choosing between economical or ethical practice (Botes & Otto, 2003; Chin, 2001; Ulrich, Soeken & Miller, 2003). The economical choice is allocating resources to clients who would benefit the most; the ethical choice requires consideration of all client interests and may encompass nonhealth outcomes (e.g., a terminally ill client may want caring more than cure) (Dowie, 2001). Justification is adopting a position "sufficiently close to various divergent positions which different groups of people regard as justified" (Norman, 2000, p. 133).

Justification is influenced by micro, meso, macro, and global level constraints. Micro constraints include limited time (Narvaez, 1991) and inaccessibility of information (Taborda & Arboleda-Florez, 1999). Meso are organizational hierarchy and professional regulations (Hamric, 2001; Keenan, 2002). Professional codes that are too restrictive or

general cannot guide professionals in decision-making about particular situations (Meulenbergs, Verpeet, Schotsmans & Gastmans, 2004). A prevailing macro level culture that values objective facts, cost effectiveness, and cure may depersonalize and exclude particular clients such as those deemed to benefit less because of developmental delays and aging (Dowie, 2001). Global postmodernist division of labour has contributed to commodification of health care as a product like any other and to diffusion of responsibility (Bauman, 1994).

Reflexivity. Professionals use reflexivity to determine their roles within the constellation of providing care and services. This involves turning self into an object of attention to distinguish motives, biases, and assumptions (Hawkins, 2001; Hepburn, 1993). Individually held goals, commitments, and ideals are compared with the needs of the situation and humanity at large (Cottingham, 1991; Flannery, 1995). Reflexivity helps correct for error or omission in one's knowledge by allowing professionals to re-perceive situations to attend to previously undetected details. It is a process of lateral thinking, flexibility, and resourcefulness that enables professionals to develop critical awareness of the meaning of their work (Peerson & Yong, 2003). It culminates in reaching a decision the professional can ultimately endorse or reject. By consistently engaging in reflexivity, professionals become more sensitive to ethical issues (Punzo, 1996).

A condition of reflexivity is detachment. Detachment is stepping back from privileged relationships and the immediacy of the situation by bracketing personal attachment to gain a wider view of differences in choice and vision (Baron, 1991; Kyte, 1996). Partiality, or giving special weight to own interests, is compared with impartiality or not giving weight to interests simply because they are one's own (Piper, 1991).

Reflexivity is influenced by capacity for mental discipline, accurate self knowledge, and propensity for self development. Mental discipline includes perseverance (Callahan, 2002; Tarlier, 2004); prudence (Callahan, 2002); and scepticism to resist being "taken in" (Symonds, 1995). Self knowledge is awareness of own strengths, weaknesses, level of preparation, and biases (Narvaez, 1991; Scanish & McMinn, 1996). Self development presupposes understanding disciplinary substance or intelligence (Procario-Foley & McLaughlin, 2003), keeping informed (Maier, 2000), zest for life long learning (Chaves, 2000), ongoing evaluation of past and future decisions (Issler, 1993), and self care agency (Flannery, 1995; May, 1992).

Boundaries

A taxonomy of ethical sensitivity characteristics has been developed (Weaver, 2005b). This can help to clearly distinguish between what is and is not ethical sensitivity. For instance, ethical sensitivity is absent if one is merely doing one's job or if others must point out the presence of an ethical problem.

Outcomes

The outcomes of ethical sensitivity in professional practice are client comfort, professional learning and transcendence, and integrity. Integrity is defined as wholeness and consistency (Nordgren, 1998). It refers to the character of the professional, the dignity of clients as persons, and the fibre of larger systems. Integrity relies on the courage and transcendence of the professional. Directing professional attention to one stakeholder (e.g., client, professional, organization, professional disciplines, or society) may negatively impact the stakeholder(s) not chosen. Therefore, integrity-preserving compromise is the ethically defensible outcome. Integrity-preserving compromise is

splitting the difference between opposing positions (Benjamin, 1991). It may evolve from mutual respect or fair hearing of opposing viewpoints of others and from re-examining perceptions and reasoning underlying personal views. Circumstances evoking compromise are complexity, the need to maintain continuing cooperative relationships, and scarcity of resources.

Transcendence is the ability to alter one's own life or the lives of others by choosing one alternative from another and in so choosing, accepting responsibility for the choice and its consequences (Travelbee, 1971). Transcendence enables one to achieve a broader perspective and to make meaning beyond the boundaries of the self (Enyert & Burman, 1999). Self interest and the role of professional must be transcended to perceive and relate to clients as human being to human being. Transcendence enables the professional to act, despite feeling "the anguish of not knowing" (Travelbee, p. 26), and to be aware of her or his own adequacy in making choices. Technical activities are transcended by considering them a means to an end, not the end itself. Transcendence is an intellectual, reflective process resulting in actions of benevolence (Lonergan, 1972).

Person-led care. When the focus of professional attention is client needs and wants, person-led care may result. Clients experience comfort and well-being from having their needs addressed, rights protected, and feelings validated by professional understanding and empathy (Bailey, 1999; Sade, 2001). Within the realm of person-led care, professionals may experience greater satisfaction and less burnout (Higgins-D'Alessandro, 2002). Clients or their relatives may reciprocate by expressing smiles, gift-giving, and interest in the professional as person (Morse, 1991). Exclusive focus on the client, however, may compromise integrity of the larger systems. For instance, the use of

misleading codes for payment of services (Sade, 2001) and misleading advice to avoid legal prosecution (Bailey, 1999) may harm reputation of professional disciplines, professional-client relationships, and public trust.

Routine-oriented care. Routine-oriented care may result when the focus is not the client but other stakeholders (Hajbaghery & Salsali, 2005). Under this condition, clients experience dissatisfaction because they expect their needs to be addressed and their emotions to matter. Their experiences of receiving care and services may be perceived as trauma (Sarat, 1991). Professional focus away from the client toward the professional may manifest as professional self-focus. Although some self-focus is needed for a fulfilled human life that involves caring for others, a negative consequence of professional self focus is client neglect. Exclusive focus on the organization may compromise the integrities of professionals, professional discipines, and clients. Rigid adherence to nonclient centred organizational policies may contribute to dehumanization of patients and moral distress in nurses who feel unable to influence the quality of patient care (Austin, Bergum & Goldberg, 2003). As a result, nurses may leave the setting or nursing (Corley, 1995; Lutzen, Cronqvist, Magnusson & Andersson, 2003; Wilkinson, 1987-88).

If the professional discipline is the focus of attention, the interests of the discipline are advanced over clients and society. Routine-oriented care may result if professional codes do not serve to protect the public from unethical practices but to secure a market niche, autonomy, and continuing funding (Dunbar, 1998; Sade, 2001; Simon, 1991). If the focus is society, social care systems are preserved while individual client rights may be curtailed. Attention focussed on the global level may effect outcomes

that include world community or solidarity (Leming, 2000; Ryu, 2001; Steinkraus, 1987), prevention of evils such as nuclear holocaust or terrorist threat (Fule & Roddick, 2004; Pawlikowski, 1984), service to societies (Bebeau, 1994), and social responsibility for the injurious actions of racism, bigotry, and hatred (Glannon, 1997; May, 1992). The preservation and well-being of the species is the ultimate aim of ethical sensitivity (Loye, 1999; Silverman, 1994). Yet, striving for ethical sensitivity at the global level diverts attention away from close up relationships (Myhrvoid, 2003).

Physiology of the Concept of Ethical Sensitivity

The physiology of a concept is its use or action. Physiology was analyzed by exploring applications of ethical sensitivity across different contexts. This enabled identification and removal of characteristics unique to individual contexts. Recontextualizing the concept revealed its nature and role in decision-making and moral development.

Use. Ethical sensitivity consists of individual components of affect, cognition, skill, knowledge, and responsibility. Responsibility is highlighted in the preconditions of relationship, receptivity, responsiveness, and courage. Affect and cognition comprise the attributes: (a) moral perception is intuitive, a combination of affect and cognition that enables direct perceptual grasp of the morality of a situation, (b) affectivity is affective and cognitive, and (c) dividing loyalties is cognitive processing and affective valuing. Achieving integrity-preserving compromise is skill in transcending a priori views and agendas. The knowledge component of ethical sensitivity traverses all dimensions. For example, the knowledge contained in codes of ethics and conduct established by each profession express a minimal level of responsiveness required for professional practice.

The knowledge underlying moral perception is experiential knowledge acquired by professionals from previous recognition of ethical issues. Knowledge of affectivity is self-awareness. Knowledge for dividing loyalties is professional and personal values, clinical findings, expert opinions, and institutional policies. To achieve outcomes of integrity-preserving compromise, client comfort, and professional learning; the professional combines knowledge with caring affect, skill, and responsibility to transcend biased views and understand all relevant perspectives and consequences.

Together, the core components of responsibility, cognition, affect, skill, and knowledge comprise the integrated process of wisdom. Wisdom has been referred to as a gift constituted by "illumination of the intellect with charity inflaming the heart" (Simpson & Weiner, 1996, p. 2325). Wisdom is the capacity of judging rightly in matters relating to life and conduct; it is sound judgement in choice of means and ends (Pellegrino, 1995). Wisdom is characterized by profound understanding; it is a consciousness of wholeness that does not lose the relativity and relationships among particular things (Curnow, 1999). Wisdom is where "self-awareness is no longer at odds with awareness of the otherness of the world" (Meeker, 1981, para 3).

Of the differing types of virtues described by Aristotle (1962), ethical sensitivity best fits *phronesis* (practical wisdom or prudence), the Greek term for applying good judgment to human activity, and hence moral intelligence. The other virtues are considered intellectual rather than moral. They include *sophia* (theoretical wisdom; scientific and intuitive knowledge), *episteme* (scientific knowledge), *techne* (craft knowledge), and *nous* (intuition). As a moral virtue, ethical sensitivity would be the mean between insensitivity and over sensitivity. For instance, it would not occur to an

insensitive individual that his or her actions or failure to act could negatively affect other (Blum, 1991; May, 1992). At the opposite extreme, an oversensitive individual could become too emotional to act with moral agency in a given situation (Smilansky, 1996).

Ethical sensitivity is both a resource that professionals bring to professional practice and a process developed within the concrete particularity of each situation. It presupposes technical competency. It prevents basing decisions on a limited perspective (Casarett, 1999; Ersoy & Gundogmus, 2003). Ethical sensitivity directs the pursuit of goodness and morally right actions, and develops through self evaluation and insight into the impact of the one's actions on others (Stilwell, Galvin, Kopta & Padgett, 1998).

Professional decision-making. The conceptualization of ethical sensitivity generated from using the Morse Criterion-based method improves on other frameworks of professional decision-making. It supports the connection between affective and cognitive elements articulated in the Rest (1982) model which was developed deductively from moral development theories. It adds clarity to Lutzen's inductively developed model (1993) wherein she defined moral sensitivity as "cognitive capacity based on intuition and feelings" (p. 10). It includes the element of professional responsibility that can be evaluated by those receiving professional care and services. Clarification of the concept has explicated the complexities and intricacies inherent in professional decision-making. It has enabled a comprehensive conceptualization of the nature, structure, and processes of ethical sensitivity in professional practice.

Discussion

The analysis of ethical sensitivity sheds light onto the longstanding issue of whether a care or justice ethical orientation will better serve nursing. Ethical sensitivity interfaces with rule, virtue, and relational based ethics. It supports a more global approach to client needs assessment.

Contribution to the caring and justice debate. Authors (e.g., Nortvedt, 1993; Sherblom, Shipps & Sherblom, 1993) report that nurses use both care and justice orientations to discern and respond to moral issues. The justice orientation, based on Kohlberg's theory of moral development (1981), involves commitment to obligation, equity, and fairness, through adoption of rules and established standards. It is anchored in the Kantian conception of justice as rational and emotion-free. The ethic of care, originating from the work of Gilligan (1982) and Noddings (1984) focuses on increasing responsibility and connectedness between self and others by learning to weigh personal desires against the needs of others. Within the ethic of care, emotions and valuing the uniqueness of the other are components of the ethical response (Noddings, 1984).

The care and justice orientations are regarded as complementary and in tension with each other. According to Gilligan and Attanucci (1988), the care orientation (i.e., seeing saliencies of persons and interconnections) precludes concurrently seeing the justice issues of fairness, rights, and obligation - a gestalt shift is needed to see first one then the other perspective. Feminist bioethicists have proposed an integrated justice and care ethic. White and Tronto (2004), for example, conceptualize care as a limited social good which should be distributed using principles of justice. They assert that a society based on principles of justice will create the social requirements for the ethic of care.

Underlying White and Tronto's argument is the assumption that care can be subjected to the same universal, impartial, abstract processes that comprise the ethic of justice. In using the ethic of justice to dominate the ethic of care, they may further dichotomize rather than integrate the ethics of care and justice. The perspective of Okin (1989) comes closer to synthesizing the care-justice issue, as she retraced the roots of the Rawlsian construction of justice and called for the feeling of care and empathy for all persons of all different positions in society.

The results of this concept analysis of ethical sensitivity describe a different way of viewing the combination of care and justice orientations in professional decision-making. The preconditions of relationship, receptivity, and responsiveness and the attribute of affectivity fall within what is commonly regarded as the care orientation. The justifying component of dividing loyalties (e.g., applying a rule or an established standard, choosing end goals and allocating resources in delivering professional care and services) fits with the justice orientation. Through reflexivity and courage, the professional melds together the complementary concerns of care and justice aspects to make decisions that foster integrity, client comfort, and learning. It must be stressed that this finding has been identified from synthesis of academic literature and further research of actual situations is required.

Integration of ethical sensitivity with principle, virtue, and relational based ethics. The concept analysis of ethical sensitivity incorporates an eclectic approach that is not inconsistent with principle, virtue, and relational based approaches. It conveys the complex backward and forward, side-to-side movement of professional engagement in decision-making with clients. It portrays ethical sensitivity as dependent on the ongoing

socialization process between the professional, client, and the supporting community. It interfaces with relational ethics in requiring relationships of engagement and obligation to the client arising from professional receptivity to client cues (Austin, Bergum & Dossetor, 2003). As well, respect and trust are critical in developing both ethical sensitivity and a relational ethic.

The conceptualization of ethical sensitivity constructed through this concept analysis suggests areas of linkage of this study with the philosophy community. One such connection is that within this analysis of ethical sensitivity, the ethical principles (e.g., autonomy, justice, beneficence, and nonmaleficence) identified by Beauchamp and Childress (2001) would tend to considered as sources of knowledge. An understanding of these ethical principles could sensitize the professional, helping to inform perceptual pick-up of client cues, and later on coming into play in informing the justification strategy of dividing loyalties. In conceptualizing ethical sensitivity as practical wisdom, the cognitive, affective, and behavioural qualities which constitute the moral fibre of the professional as an ethical agent develop within the experience of the particular care situation. This experience enables the professional to transcend unenlightened views of the client, situation, or self and to carry informed views forward to new situations. In this regard, ethical sensitivity as described in this concept analysis may tentatively interface with the theory of virtue espoused by Pellegrino (1995; 2002; Pellegrino & Thomasma, 1993) as necessary for medical practice and the focal virtue of discernment that Beauchamp and Childress (2001) say "bring sensitive insight, acute judgment, and understanding to action" (p. 34). These areas where further research is suggested have not been fully developed or argued,

Assessment of client needs. The identification of the outcome of integrity-preserving compromise and of problems associated with adopting a pure client perspective contributes new understanding to client assessment. The results provide limited support for Kikuchi's argument (e.g., Kikuchi, 1999; Kikuchi & Simmons, 1999) that nursing interventions be based on professional judgement of client needs rather than solely on client preferences. The results further push thinking beyond the limitations of need identification from either the client or the professional perspective to encompass consideration and integration of all relevant stakeholder perspectives.

Significance of the Findings to Nursing and Other Disciplines

Analysis of the concept of ethical sensitivity provides a language and process for professionals to communicate the ethical dimension of their work. It explicates ethical issue recognition and professional responsiveness, contributing a new perspective to the care-justice debate and issue of client assessment. It may be integrated with and to some extent augment other frameworks of ethical and professional decision-making.

The findings further illustrate the efficacy of the Morse Criterion-based method of concept analysis in developing disciplinary knowledge. Use of this method enabled fresh understanding of how the care and justice ethical orientations could be integrated in professional decision-making. The Morse Criterion-based method infused potency to the concept of ethical sensitivity by enabling consolidation of its incomplete definitions and descriptions. The results have brought new knowledge into disciplinary conceptual bases to guide research and theory construction. The consolidated understanding of ethical sensitivity can serve as a frame for evaluating and developing professional decision-making.

Summary and Future Directions

This concept analysis using the Morse criterion-based method for exploring pragmatic utility has built an essential foundation for on-going research about ethical sensitivity. Various features concerning the development of ethical sensitivity that establish its preconditions, attributes, and outcomes have been identified. The analysis advanced comprehension of ethical sensitivity to better understand the nursing and other professional disciplinary perspectives in providing care and services.

The role of the personal characteristic of courage, the influence of support and of organizational control on professional autonomy, and the potential integration of the care and justice ethics require further investigation. It is not known exactly how professionals develop the courage to act wisely in responding to the demands of clients and situations. There is a need to study collegial, administrative, organizational, and interdisciplinary support, particularly under conditions of limited professional autonomy. Knowledge of these external and internal influences may benefit practitioners, educators, and administrators by raising awareness of the requirements and processes for developing ethical sensitivity in professional practice. Further comparison of the innovative synthesis of care and justice resulting from this concept analysis is required to identify its potential contribution to practice. In subsequent phases of this research program, the utility of the concept for application to education will be advanced with the ultimate goal of enhancing professional practice through theory development.

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Chapter 5

GUIDELINES FOR ENHANCING THE EDUCATIONAL DEVELOPMENT OF ETHICAL SENSITIVITY

Ethical sensitivity on the part of professionals influences how clients experience professional care and services. The literature abounds with numerous educational strategies to help students in professional disciplines develop ethical sensitivity. These strategies differ widely, address specific individual components of ethical sensitivity, and for the most part are not based on a comprehensive understanding of what the concept entails. The development and expression of ethical sensitivity in professional practice may be limited if students do not learn a more comprehensive pattern of strategies reflective of the complex, multidimensional nature of ethical sensitivity. In this article, a format for clinical and classroom teaching based on the results of rigorous analysis of the concept is proposed. Challenges and benefits for its implementation are described. Areas for further research to enhance design and implement more efficacious teaching interventions are suggested.

Background: Issues in Teaching Ethical Sensitivity

The concept of ethical sensitivity communicates an aspect of decision-making that is expressed through professional concern and moral obligation toward alleviating suffering and the protection of vulnerable clients. Because the concept has been an implicit part of professional care-giving, its contribution to science has not been well-recognized. Psychologist James Rest with colleagues Muriel Bebeau and Catherine Yamoor (1985) operationalized the concept as ability to interpret both the client needs and the effect of the professional's actions on the client's welfare. Since then, scholars

from other professional disciplines[1] have continued to describe the concept. This accumulated body of literature permitted systematic analysis of the utility of the concept to disciplinary research, theory, and practice (Weaver, 2005a, 2005b).

The analysis reveals problems related to the concept as an emerging and partially mature concept with limited usefulness to education. The limitations include lack of disciplinary and interdisciplinary agreement, difficulty in measurement, assumptions that ethical sensitivity is the same as empathy and compassion, inadequate attention to institutional environmental factors that hinder development of ethical sensitivity, and constricted view of ethical sensitivity to what can be learned and evaluated in an academic term of a professional educational program. Each of these five factors is discussed briefly below.

1. *Lack of disciplinary and interdisciplinary agreement.* Ethical sensitivity is an emerging, partially mature concept that represents the poorly or incompletely understood phenomenon of professional identification and responsiveness to the ethical import of a situation of giving care. There are gaps or discrepancies regarding the concept anatomy or internal structure (e.g., definition, preconditions, attributes, boundaries, and outcomes) and physiology or application (e.g., may not be used consistently across contexts). The literature contains numerous examples of teaching strategies to help professionals develop ethical sensitivity in practice. These strategies are based on insular definitions of ethical sensitivity that have not achieved disciplinary or interdisciplinary consensus (Weaver, 2005a). Thus there is disagreement regarding how to help students develop ethical sensitivity.

[1] Professional disciplines are specialized branches of knowledge, each with a unique perspective for viewing and constructing knowledge about its phenomena of interest (Donaldson & Crowley, 1997/1978).

Typically, educational courses and programs have focused on cognitive, affective, and skill components of ethical sensitivity. The cognitive component is taught as exemplars containing ethical issues within hypothetical or real life situations. The affective component is taught through exposure to and discussion of literature and films from the humanities or liberal arts to kindle emotional responses. The skill component is taught through experiential role-taking and communication activities. The problem with focusing on individual components of cognition, affect, and skill is that other components (i.e., knowledge sources and responsibility) which comprise ethical sensitivity are inadequately addressed, and student learning is compromised.

2. *Difficulty with measurement of ethical sensitivity.* Ethical sensitivity is measured via problem based scenarios or attitude surveys. The scenario approach, originating with Rest and colleagues (1985), depicts ethical sensitivity as recognition of client needs and professional role in real-life or hypothesized situations. The use of scenarios as instruments may distort measurement of ethical sensitivity by conveying a negative connotation for the concept (i.e., ethical sensitivity is useful to situations wherein problems already exist) which may restrict its application in promoting care and anticipating problems. Hypothetical situations may oversimplify the task by reducing the noise inherent in real life ethical quandaries (Yetmar & Eastman, 2000). Moreover, if limited to one-to-one interactions between clients and professionals, measurement of ethical sensitivity via scenario responses, may be unsuitable for more complex situations of practice (Clarkeburn, 2002b).

Difficulties are also associated with attitudinal surveys such as the Moral Sensitivity Questionnaire developed by Lutzen and colleagues (1994) which uses Likert

measurement to rate responses to value statements. The difficulties relate to an underlying assumption that professionals base decisions on attitudes. This may be inaccurate, for professionals may not act on their beliefs and values as they would respond in actual practice situations. Another assumption is that there are general values and agreement over how to transfer these values to students. This, according to Clarkeburn (2002a), is erroneous. The difficulties in measuring ethical sensitivity with available scenario or attitude based instruments invalidate the effectiveness of educational efforts to help students develop ethical sensitivity.

3. *Assumption that empathy and compassion equate to ethical sensitivity.* Empathy, compassion, and ethical sensitivity all involve responding to the suffering of others with identification, concern, and tolerance. Without these qualities a professional is not affected and fails to connect with the client (Scott, 1995). Empathy is the power of projecting one's personality into and comprehending the other (Simpson & Weiner, 1996, p. 508). Empathy is emotional and physical. Emotional empathy is arousal or responsiveness resulting in insight (Morse, Miles, Clark & Doberneck, 1994). Physical empathy or compathy is insight of the experience of the physical distress or pain of the other (Morse & Mitcham, 1997; Morse, Mitcham & Van der Steen, 1998). Compassion is immediate acceptance of the legitimacy of another's distress (Morse, Bottorff, Anderson, O'Brien & Solberg, 1992).

Ethical sensitivity differs from emotional empathy and compassion in that ethical sensitivity requires the professional to take self as well as client into account, to understand the needs of all stakeholders affected by the situation, and to bridge differences between stakeholders. Empathy and compassion focus on the client and

similarities between the client and professional. Ethical sensitivity differs from compathy, in that compathy is insight into the physical experience of the other while ethical sensitivity includes and extends beyond this embodied response to discern the ethical dimension and ramifications of the situation. Ethical sensitivity is related to obligations to clients as per the profession's code of ethics (Bebeau, 1994; Brabeck et al., 2000). Empathy and compassion relate to general societal obligations. Given these differences, it cannot be assumed that teaching empathy and compassion will adequately prepare practitioners for the ethical demands of practice.

4. *Inadequate attention to organizational factors.* Loyalty to employing institutions influences professionals' perceptions and judgement of the ethical aspects of situations (Oddi, Cassidy & Fisher, 1995; Wittmer, 2000). Loyalty to professions, however, has not been found to influence ethical sensitivity (Shaub, Finn & Munter, 1993). This suggests that focussing educational interventions on professional intrapersonal development and on commitment to the principles of a profession (i.e., as expressed in professional codes of ethics and conduct) may be ineffective if external organizational practices, policies, and constraints that deter expression of ethical sensitivity are not addressed.

Organizations reward those who comply and punish those who do not (e.g. fire whistle blowers) to exact loyalty and preserve the organization's autonomy (Cherrington, 2002; Grant, 2002). Employing institutions control the amount and type of contact between professionals and clients and may thereby restrict professional responsiveness to clients. Nurses, for example, may ignore their own judgement to adhere to insurance guidelines (Ulrich, Soeken & Miller, 2003). Teachers may be forced to implement

curricula and standardized testing to which they are uncommitted (Diegmeuller, 1994; Higgins-D'Alessandro, 2002). Managers may regard unethical practices acceptable if performed in the interests of the organization (Mudrack, Mason & Stepanski, 1999; Patterson, 2001). Under conditions of compliance with organizational criteria, professionals may ignore ethical issues.

5. *Constricted view of ethical sensitivity.* Clarkeburn (2002a) limits teaching ethical sensitivity to what can be accomplished within a discrete unit of a professional program. He argues virtue approaches are inappropriate as it is unreasonable to change character in the space of one ethics course or academic term. He determines that skills are appropriate.

The problem with teaching ethical sensitivity as a set of skills that can be learned within a discrete time period in a simulated environment is that other essential components (e.g., affect, sources of knowledge) are not developed. A skills-based approach may reduce professional response to predetermined activities and limit critical thinking, creativity, and responsiveness. Further difficulty may be encountered as the skills needed for ethically sensitive practice have neither been explicitly identified nor validly evaluated.

Concept Analysis: Process of Developing Ethical Sensitivity

Success or failure in making good ethical decisions depends on the ethical sensitivity of the professional as moral agent (Punzo, 1996). To increase understanding of the role of educational interventions in the development of ethical sensitivity, an exploration of the pragmatic utility of the concept of ethical sensitivity in professional practice was conducted using the Morse Criterion-based method of concept analysis. The

method involved critical appraisal of the scientific literature to comprehend concept anatomy and physiology. Analytical questions, derived from reflection upon the literature, were asked of all of the literature to push beyond the boundaries of current knowledge about the concept. A detailed explication of the nature, anatomy (including definition, preconditions, attributes, and outcomes), and physiology (manifestations of the concept in various contexts) emerged. This explication served as a framework into which results were synthesized from asking the following analytical question: "Assuming that ethical sensitivity or at least some aspect of it can be taught or learned, what if any strategies best prepare professionals to develop ethical sensitivity?"

Conceptual framework. Ethical sensitivity, in the context of professional practice, is defined as deciding, acting wisely and compassionately within a given care situation based on profound understanding of sources of knowledge including professional codes for ethical conduct, clinical, academic, and self (e.g., experiential and internalized values) knowledge; anticipation of the consequences of decisions and actions; and courage to take appropriate action (Weaver, 2005b). The analysis portrays ethical sensitivity in professional practice as a type of practical wisdom that professionals bring to and further develop in particular practice situations. Ethical sensitivity is informed by affective and cognitive processing, use of multiple sources of knowledge, skill, and responsibility on the part of the professional. Through ethical sensitivity, professionals accurately recognize and respond to alleviate suffering and to protect vulnerable clients. Ethical sensitivity has universal properties including emotional arousal; yet, it is capable of being modified (i.e., dulled, heightened) via environmental interventions.

Ethical sensitivity presupposes disturbance in the professional's sense of certainty about a situation. Preconditions of ethical sensitivity are exposure to client cues of suffering and vulnerability (e.g., pain, threat to health and well-being, and attention to health and illness needs) and relationships characterized by the professional's receptivity, responsiveness, and courage. Receptivity enables professionals to pick up on client cues. Responsiveness is the professional's caring intent and obligation to enhance client comfort and well-being. Courage is required for the professional to resist predominant views, values, and expectations (Weaver, 2005b).

Attributes (characteristics present in all instances of the concept) identified through rigorous concept analysis are: moral perception, affectivity, and dividing loyalties. Moral perception is affective, cognitive, and intuitive discernment of the ethical dimension of a situation. It begins with an awakening which impels the professional to further read the situation to discriminate an actual or potential ethical problem. Affectivity is the professional's embodied response to the client. Through dividing loyalties, a strategy of interpretation, justification, and reflexivity to gain the most informed understanding about the client and situation, the professional decides the focus and course of action.

Outcomes are integrity-preserving compromise, client well-being, and professional learning and transcendence. Compromise results in person-led or institutional-based care. Person-led care is associated with greater client and professional comfort, well-being, and satisfaction. Institutional-based care results from professional focus on self, organization, profession, or society. Although institutional based care may benefit organizations, professions, and societies; it evokes client and professional

distress. Learning from the experience of developing ethical sensitivity in a particular situation enables the professional to transcend old views of client, self, and situation and to carry forward this knowledge to new situations (Weaver, 2005b).

Synthesis of educational interventions. Various educational interventions including diverse instructional modes, methods, and media described in the professional literature were matched to the conceptual preconditions, attributes, and outcomes. Specific instructional modes include group activities, interdisciplinarity, and individual journaling. Methods involve role taking, discussion, role modelling, and clinical supervision. Learning media incorporate real-life and fabricated case studies, dilemma-based scenarios, and literary or motion picture art. A comprehensive framework to direct the design of educational programs was created from fitting the interventions into the conceptual dimensions (see Table 5-1).

The framework illustrates the complex array of strategies to help professionals learn to respond to clients beyond the technical requirements of their disciplines. For instance, to effect integrity preserving compromise, professionals must learn public deliberation, a type of policy-making theory that moves away from political policy as instrumental rationality and toward interactive communicative and transparent practices (Bracci, 2001). The framework conveys that the need for teaching ethical principles and professional codes of ethics be balanced with an understanding that knowledge of ethical principles and codes is not enough. The framework encompasses interventions for teaching professional self-understanding and self scrutiny to fully grasp client needs and develop capacity to influence the situation (Punzo, 1996; Sherwin, 2001).

Table 5-1

Framework for Teaching Ethical Sensitivity

Precondition	Actions	Rationale
Suffering and Vulnerability Cues	Highlight social and environmental context. Brief/debrief for field work. Discussion of stories about emic perspectives.	To alert students to disparities and cross-cultural issues (Leming, 2000; Robson, 2002). To challenge apriori assumptions about attitudes, values, and behaviour patterns of characters (Schnitzer, 1996).
Uncertainty	Teach to cultivate uncertainty	To break open established terms of judgment (Connolly, 1993)
Relationship	Teach communication therapeutics (e.g., listening, attending, empathy) via role taking exercises. Educators to role model knowledge, skills, and attitudes in their interactions with others.	To learn the client perspective (Conway, 2000). To provide experiential experiences and feedback (Housman & Stake, 1999; Kitchener, 1992). Students will not treat clients appropriately if treated harshly themselves or they observe unethical treatment by educators (Branch, 2000; Canon, 1992; Self & Baldwin, 1994).
Receptivity	Exposure to other cultures, life experiences, and histories. Teach to develop skills to listen, learn from others, and critically evaluate. Group work that fosters compassion, concern for social justice, and respect for diversity (e.g., values clarification exercises). Establish learning atmosphere of acceptance and community for discussing practice and learning issues (Hall, 1987).	To inoperate prejudice by making it intellectually indefensible (Goldman, 1977). To understand the other's worth and claims (Conway, 2000; Gross, 2001). To provide safety for students to explore and develop skills and attitudes that lead to altruism, cooperation, and social responsibility (Lerman, 1998).

Table 5-1 (Continued)

Framework for Teaching Ethical Sensitivity

Precondition	**Interventions**	**Rationale**
Responsiveness	Emphasize human rights and responsibility. Teach to assess client reactions to professional's actions	To foster answerability to those served (Botes, 1999; Lutzen & Nordin, 1993).
	Role taking experiences (e.g., mock trials).	To identify blind spots in seeing others' perspectives (Branch, 2000)
	Support students to have therapy if needed.	To learn about self, identify errors in thinking, and become aware of personal reactions (Layman & McNamara, 1997; Lipson & Lipson, 1996)
	Take advantage of educational opportunities for ethics training.	To increase awareness of ethical issues and build leadership ability (Erwin, 2000; Penticuff & Walden, 2000).
Courage	Establish supportive, longitudinal, and national peer networks.	To foster solidarity and commitment (Goldie, 2000; Scanish & McMinn, 1996).
	Support and expect students to place client and public interest above self-interest, to profess collectively and publicly, and to participate in negotiating social contract between the profession and society.	To emphasize responsibility and commitment toward social order and services (Botes, 1999; Chin, 2001).
Attribute	**Interventions**	**Rationale**
Awakening	Stimulate cognitive and moral dissonance (e.g., assign to unpopular side of debates).	To disrupt taken for granted beliefs and assumptions (McPhail, 2001).
	Encourage students to stay informed in substantive area (e.g., research updates).	To be more perceptive to changes (Jeffers, 2002).
	Incorporate "noise" in classroom learning examples.	To increase cognitive effort and real world distractions (Yetmar & Eastman, 2000).

Table 5-1 (Continued)

Framework for Teaching Ethical Sensitivity

Attribute	Interventions	Rationale
Particularity	Clinical experience with exposure to varied examples.	To build storehouse of accessible prototypes from which to recognize ethical issues in new situations (Sherwin, 2001).
	Teach variety of ethical principles and theories.	To illuminate dimensions of issues difficult to see from a single theoretical perspective (Coleman, 2002; Sherwin, 2001).
Affectivity	Explore and discuss humanities and liberal arts literature, history, stories, films, and poetry.	To increase understanding of basic life situations (Goulston, 2001); to prime moral imagination, creativity, and appreciation of people's lives outside the domain of professional care (Killen, 2002; Macnaughton, 2000; McPhail, 2001); to evoke sentiments and present concrete human and interpersonal situations at an easily absorbed level of understanding (Leming, 2000).
	Clinical supervision.	To help learners choose appropriate responses to meet demands of clinical experience (Fowers, 2003). To clarify relational boundaries (Housman & Stake, 1999) and sources of frustration with self and others (Shaner, 1989).
	Small group discussion of situations that engage students' imaginations and feelings.	To expose hidden prejudices and fears (Macnaughton, 2000).
Interpreting	Develop capacity for emotional empathy (e.g., perspective taking activities).	To understand client plight and interests and to foster learning different perspectives in a situation (Bailey & Piercy, 1997; Garrod, 1989)

Table 5-1 (Continued)

Framework for Teaching Ethical Sensitivity

Attribute	Interventions	Rationale
Interpreting (continued)	Pursue multiculturalism through role play, reviewing ranges of cases and policy alternatives, considering whose interests are taken into account, and attending to the position of socially oppressed groups.	To ensure taking in perspectives of those differently situated than self, gain familiarity with social policy, and appreciate the need to adopt a more complex qualified response (Conway, 2000; Sherwin, 2001).
	Interdisciplinary observation and discussion of individual-organizational processes (e.g. team or board meetings, ethics committees).	To expose students to diverse complementary perspectives and to aid recognition of relevant stakeholder interests (Gastmans, 2002; Payne & Giacalone, 1990).
Justifying	Have students evaluate biased reports. Teach how to order thoughts, construct arguments, and reach logical conclusions.	To seek truth (Goulston, 2001), question received wisdom (Macnaughton, 2000), and to learn the importance of evidence and how it can be manipulated (Hall, 1987).
	Teach professional codes of ethics and ethical decision-making models.	To judge the harm and benefit to others in light of professional values (Coleman, 2002)
	Comparative analysis (i.e., use two or more groups with vastly different experiences.	To show the examples were not problems to be addressed only within the confines of a particular group (Goldman, 1977).
	Group activities – experiential learning activities (e.g., mock custody trials, scenarios, case studies).	To evaluate legitimacy of conflicting positions and understand the feelings, needs, and behaviours of others (Hall, 1987; Higgins-D'Alessandro, 2002).

Table 5-1 (Continued)

Framework for Teaching Ethical Sensitivity

Attribute	**Interventions**	**Rationale**
Reflexivity	Individual and collective processing of clinical and humanities based issues. Personal value journal. Encourage to distinguish between technical (what is possible) and ethical (what ought to be done).	To promote introspection and reflection skills (Baarts, Tulinius & Reventlow, 2000). To explore feelings and identity (Lerman, 1998; McPhail, 2001). To step outside the mind set to judge the worth of technical approaches in light of personal and/or professional values (Conway, 2000).
Outcome	**Interventions**	**Rationale**
Integrity Preserving Compromise	Teach to foresee moral consequences of actions. Decision making interactive and transparent. Foster mutual respect or fair hearing of opposing viewpoints and re-examination of perceptions and reasoning underlying personal views. Teach students to consider all salient features of a situation before making decisions.	To base decisions on welfare of others and self (Gredley, 2000). To avoid imposing instrumental rationality (Bracci, 2001). To understand negative impact from directing professional attention to one over another stakeholder (e.g., client, professional, organization, profession, or society) (Benjamin, 1991). To take into account complexity, and to preserve cooperative relationships and scarce resources (Benjamin, 1991).
Person-led care	Students to engage in sustained interactions with clients. Teach to intervene with clients to help clients attain health and well-being outcomes (e.g., provide information, teach problem solving skills).	To educate and humanize the professional by absorbing from client exposure (Scott, 1995). To help clients change behaviour (Bailey & Piercy, 1997).

Table 5-1 (Continued)

Framework for Teaching Ethical Sensitivity

Outcome	Interventions	Rationale
Person-led care (continued)	Critique of client evaluations and program evaluations.	To build awareness of professional therapeutic agency (Scanish & McMinn, 1996).
Professional Learning & Transcendence	Evaluate students on what they do to get at the client's point of view and what they have learned about the client's perceptions of problem (Smith, Dollase & Boss, 2003).	To validate self evaluation by grasp of client needs and assessment of client reactions to professional actions (Lutzen & Nordin, 1993).
	Provide forums for students to explore their own and peers' identity, growth, and learning.	To base skill development on reflection on values underpinning actions (Procario-Foley & McLaughlin, 2003).
	Explore own learning outcomes in terms of breadth (seeing variation in possibilities) and depth (inwardly directed understanding).	To guide on-going self transformation and self scrutiny by transcending self interest and fully grasping capacity to influence the situation (Keekes, 1984; Punzo, 1996; Sherwin, 2001).

The teaching thrust of the preconditions is helping students be answerable to clients. The focus of the attributes is learning to recognize and process ethical issues. To achieve appropriate outcomes, professionals must learn to foresee the moral consequences of possible actions and to act in ways that preserve integrity of clients and relevant stakeholders. Teaching ethical sensitivity must involve helping professionals to gather and interlace all of the salient features of a situation before understanding can emerge. They must have ample opportunity to integrate the learning from various educational strategies (Gastmans, 2002; Pettifor, Estay & Paquet, 2002).

Consolidating the interventions highlights aspects of ethical sensitivity omitted in current teaching practice as reported in professional literature. For example, there is a dearth of interventions to help students learn to cultivate the preconditions of uncertainty and courage. Students need to learn to open up uncertainties within established terms of judgment (Connolly, 1993). They need support to develop courage to take right action.

Benefits of Using Educational Guidelines for Enhancing Ethical Sensitivity

The framework of guidelines serves as a starting place for opening a dialogue to evaluate interventions educators are already using to enhance ethical sensitivity and for determining research priorities to build the science to guide practice. It reveals a set of interventions that enable the professional, from the onset, to perceive the ethically salient features of a situation and the need for action on informed judgement. The process for comprehensive recognition of ethical import is difficult because there are inextricable webs of social custom, personal and relational histories, and competing needs and interests. The professional must learn to take into account the unique features and the ethical relevance of the situation, the persons involved, and their relationships. According to Punzo (1996), the professional must necessarily immerse in the specifics of the situation rather than try to apply universal principles. Learning such a process will be challenging. The educational interventions help prepare professionals to analyze clinical situations, identify moral issues, and become aware of own values and knowledge as well as those of other stakeholders (Goldie, 2000; Goulston, 2001).

Concern for the student as person is reflected through educational interventions about the role of educator (i.e., as role model). Although this falls within the domain of good teaching practice, it is included as an educational intervention because it

accentuates the need for students to be educated to treat those they serve responsibly, ethically, and respectfully. The guidelines reinforce the need for educators to balance compassion and support for students with welfare of clients and academic and professional standards of the institution. Educators must demonstrate integrity in relationships by being fair or just, giving timely feedback, respecting autonomy, and being honest and respectful in their relationships with students (Kitchener, 1992). They must not harm students from misuses of power.

The compilation of educational strategies serves as a resource to guide and evaluate the content of professional programs required for ethical sensitivity. It is helpful that the strategies are drawn from multiple disciplines, have been published in peer reviewed literature, and are already used to prepare students for ethically sensitive practice.

Challenges to Teaching

The benefits of the educational strategies described in professional literature must be considered against the challenges to teaching students to develop ethical sensitivity. These challenges include countering educational practices that desensitize students, overcoming resistance to the vulnerability and uncertainty required in cultivating ethical sensitivity, and adequately preparing educators for the task. Issues in the timing and sequencing of interventions, interdisciplinarity, and clinical supervision are discussed.

Desensitization of professionals through educational practices. Professional socialization may "overemphasize the technical so as to blind the professional to the moral" (McPhail, 2001; Puxty, Sikka & Willmott, 1994; Rest, 1986). Students must absorb large amount of factual information in a limited time (Baldwin & Bunch, 2000).

They may be exposed to clinical training that contradicts or trivializes ethical sensitivity toward clients. For example, using clients as means to learning may conflict with the best interests and well-being of clients (Braunack-Mayer, 2001; Robins, Braddock & Fryer-Edwards, 2002). Teachers may take over procedures, reducing student learning and participation (Coleman, 2002). Academic institutions may tolerate cheating (Glick, 2001) and may mask student withholding knowledge and expertise from each other as "competition" (Chin, 2001). These insidious practices must be addressed for students to develop ethical sensitivity throughout the course of professional schooling.

Resistance to ethical sensitivity. Ethical sensitivity enables professionals to recognize the painful intensity and the dehumanizing and destructive structures that cause suffering (Procario-Foley & McLaughlin, 2003). The recognition of suffering and vulnerability cues of clients requires professionals to expose their own vulnerability, manage the discomfort of receiving the client's distress, and suspend moral certainty about the client, situation, and helping role. These requirements may conflict with student ideas about professional role and produce anxiety. As protection, students may develop a "cynical instrumental view" and style reflecting a high degree of poise and control with a noticeable absence of vulnerability (Lerman, 1998, p. 477). They may put on ethical blinders to filter some facts as irrelevant and become more concerned with applying rules than understanding context (Lerman, 1998). They may retreat from the ethos of relieving suffering by interpreting client symptoms as "feigned" or the norm (and thus acceptable to the client) or by avoiding what is best for the client by stressing what the client wants (e.g., he doesn't want treatment, just a place to stay) (Shaner, 1989, p. 786). Professionals may adopt what Shaner (1989) refers to as "survivalist mentality" (p. 786) to defend

against the uncertainty of not knowing what is right or best to do rather than to use the pull of uncertainty to guide seeking client and other stakeholder perspectives. The challenge is to find a balance so that "suffering [does] not overwhelm and endurance with integrity . . . [is] possible" (Cannon, 1985, p. 44).

Role of educators. Teaching students to develop ethical sensitivity calls upon educators to possess the qualities required to facilitate discussions, engage students in group work, and design experiential classroom exercises such as role play and mock trials. Because educators in professional disciplines are primarily hired for their intellectual prowess and research interests in a substantive area, they may lack the preparation to interact with students in these ways. They are expected to serve as exemplary role models without perhaps having experienced being mentored that way themselves. Moreover, they may not be knowledgeable enough about ethical theories, principles, and decision-making models to teach others. Educators may have difficulty achieving an approach which the literature warns as needing to avoid (a) conveying ethical sensitivity as only right answers and right approach to care situations and (b) presenting ethics as all "grey areas" that lead students to feel there are no good solutions but only problems (Marta, Attia, Singhapakdi & Atteya, 2001).

Timing and sequencing issues. Matching educational strategies to conceptual dimensions suggests a sequence that corresponds to recommendations in the literature. For example, Goldie (2000) has recommended role modelling and longitudinal peer support groups begin at the earliest stage of training. Baab and Bebeau (1990) have reported that increasing number of discussion groups, adding prediscussion lectures on ethical theory and principles, and having educators attend a seminar on small group

dynamics increased the development of ethical sensitivity for dental students. All these interventions foster preconditions of relationship, receptivity, and responsiveness and the attribute of justification.

The interventions within the framework of guidelines need further development and testing to determine their value to professional disciplines. In addition, the delivery of the interventions will require rigorous study. For instance, it is suggested that 20 hours of small group discussion and case-based problem solving of ethical issues (Chaves, 2000) and that a 4-12 week program and facilitated dilemma discussions are most efficacious (Clarkeburn, 2002a). It is suggested that case studies or scenarios be used to teach and internalize professional codes of ethics by tying identification of intolerant behaviour to professional values expressed by the codes (Brabeck et al., 2000; Meulenbergs, Verpeet, Schotsmans & Gastmans, 2004). Chin (2001) recommends professional codes be incorporated into the mission statements and policies of organizations. Without rigorous study of these suggestions, educators will be deprived of the opportunity to choose research based, scientifically sound interventions for classroom and clinical teaching.

It is not known whether interventions are best integrated throughout a program of study or contained in a single course at the end of the program (McPhail, 2001). A separate course in ethics is recommended because ethics training by osmosis or by demand (i.e., ethics only discussed if the student raises an issue) is inadequate (Krawczyk, 1997). The danger of this approach is that ethics could be relegated to just the individual ethics course rather than treated as an aim of professional practice. It is important the framework of guidelines be examined alongside existing content and

process in professional programs to determine areas of overlap and areas that could be blended with clinical or academic content. When possible, interventions to foster ethical sensitivity should combine with technical content (e.g., students could participate in simulated team or board meetings to interpret relevant stakeholder perspectives in teaching of such issues as palliative care and insider trading). This could enhance student learning and retention as well as help educators overcome concern that ethical content will detract from other curricular areas.

Interdisciplinarity issues. Teaching ethics should focus on attitudes, integration, and context including interdisciplinary consultations (Gastmans, 2002). This permits addressing problems too complex to be solved by a single discipline (Procario-Foley & McLaughlin, 2003). The benefits of interdisciplinarity are the opportunity for scholars in related fields to cooperate with each other, sharing expertise and knowledge to better prepare for meeting common ethical challenges. The dark side of interdisciplinarity is that members of individual disciplines may not know how to pool their collective resources and may interact though misunderstanding. There is always potential for disabling power positions to emerge and control. Interdisciplinarity requires a culture wherein experts are able to become neophytes, language barriers can be overcome, and there is safety to make and learn from mistakes (Giacomini, 2004). Without strong institutional commitment, it will fail (Gross, 2004). The way for members of diverse disciplines to work together requires further study.

Supervision issues. Clinical supervision is believed to increase ethical sensitivity (Scanish & McMinn, 1996). Supervision involves triple goals of education and evaluation, obligation for the welfare and treatment of the client, and concern for the

reputation and effectiveness of the institution or profession. Although supervision is a key requirement for licensing in certain disciplines and has been relied upon as an effective teaching strategy, its effectiveness is questionable. Findings convey only 50% of students discuss ethical issues with supervisors (Housman & Stake, 1999). Supervisors may not be aware of actual moral issues in professional practice (Erwin, 2000). They may do a better job telling others how to behave than identifying their own obligations (Kitchener, 1992). For supervision to be an effective tool in the development of ethical sensitivity, supervisors must evaluate the level of development of their own ethical sensitivity, take advantage of educational opportunities for ethics training, receive training in ethical issues unique to supervision, and attend to ambiguous issues (e.g., dual relationships) as they arise (Erwin, 2000).

Evaluation of ethical sensitivity. Absent from professional literature is consideration of who should be involved in evaluating the ethical sensitivity of professionals. Currently, professions and academic and employing organizations assume this responsibility. Given that the outcomes of ethical sensitivity include person-led care and client well-being, it may be myopic to exclude the client contribution. The issue of evaluation requires discussion. As well, the findings of the concept analysis of ethical sensitivity underscore the need to better assess, evaluate, and communicate the ethical demands of situations of professional care.

Conclusion

Educational strategies designed to help students enhance their ability to recognize situations as ethical, to discern the feelings and needs of others and self, and to explore issues in particular practice situations are profuse in the professional literature.

Comprehensive and effective strategies that aid development of ethical sensitivity in professional practice must be built on the clinically based theoretical foundation explicated from analysis of concept structure and action. The results from matching individual interventions to dimensions identified by exploration of the pragmatic utility of the concept of ethical sensitivity have revealed a framework of the ethical requirements for praxis that must be learned beyond the technical requirements of professional disciplines. This framework may serve as a tool to open dialogue between professionals and educators. It provides a more integrated format of interventions than what are available in individual studies. It reveals gaps in current understanding and teaching (e.g., need to cultivate uncertainty and courage), and areas for further research (e.g., need to scientifically evaluate effectiveness of interventions such as interdisciplinarity and clinical supervision). Using the framework, educators can affect the learning process by selecting from the full-spectrum of interventions that address the multifacetted nature of ethical sensitivity in professional practice.

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Final Chapter

CONCLUSION

The results of this dissertation offer a different way of understanding ethical sensitivity than has heretofore been presented. Using the Morse Criterion-based method (2000) for concept analysis and the academic literature as data, I determined the essential characteristics of how professionals develop their capacity to interpret and respond to the needs of their clients. I applied this enhanced comprehension of the concept to evaluate the adequacy of educational strategies to help students and professionals develop ethical sensitivity for practice. I evaluated the efficacy of the research method to develop knowledge for nursing and professional practice, while at the same time, developing my own research abilities.

General Discussion and Conclusions

Ethical sensitivity is "capacity to decide and act wisely and compassionately within the uncertainty of a given care situation that draws on a critical understanding of codes for ethical conduct, clinical experience, academic learning, and self knowledge; it also includes the ability to anticipate the consequences of decisions and rests on courage" (Weaver, 2005, p. 139). This definition was constructed from analysis of definitions and theoretical descriptors of ethical sensitivity contained in academic literature. It is a consolidation of particular components of responsibility of the professional toward clients; ethical knowledge derived from codes of ethics, academic and clinical information, and experience; cognitive processing to fully understand a situation of professional-client care in terms of the need for ethical decision-making; the affective response of the professional to the client's plight; and skill development

critical to professional service to others (i.e., communication, perspective-taking, and self-scrutiny). Together, the components form a comprehensive core of practical wisdom, beyond which ethical sensitivity is irreducible, that is, all components must be present for the concept of ethical sensitivity to occur. The consolidated definition adds clarity to the clutter of terms in the literature and can serve as a standard for evaluating the adequacy of other definitions.

Exploration of the concept of ethical sensitivity generated insight and new knowledge of the preconditions, attributes, and outcomes which can guide decision-making, communication, client care, and inter-professional relationships, hence improve care. While preconditions of relationships of engagement characterized by receptivity and responsiveness are not, the preconditions of uncertainty and courage are surprising. Uncertainty is ardently opposed in some disciplines and considered undesirable (Lerman, 1998; Shaner, 1989). Yet, it is essential for ethical sensitivity for two reasons. First, it must be deliberately cultivated to overcome blindness associated with moral certainty when a professional may not adequately interpret, justify, and reflect on all options. In such instances, without uncertainty, opportunity to more accurately identify client needs is diminished and contribution to decision-making is restricted. Second, adopting an attitude of uncertainty may serve to maintain focus on the client. A professional who seeks to adopt this attitude will revisit and reappraise views of the client and the situation.

Courage is needed for professionals to be prepared to challenge views of self, clients, situation, other professionals, and even, on occasion, standard practice. The precondition of courage evokes images of soldiers armed for battle. Indeed the

conditions of contemporary professional practice may resemble messy battlefields which inspire professionals to run and hide rather than stay and provide quality care and services. The analysis identified the importance of support in helping professionals to develop courage. As courage is not a typical content area of professional courses and programs, further exploration is needed.

The concept analysis defines person-led care as professional focus on client, and routine-oriented care as professional focus on self, organizational, professional discipline, or society. The professional acts ethically to address a care situation based on (a) knowledge of all relevant perspectives, needs, and interests, (b) knowledge of self, and (c) freedom to act within the professional or organizational hierarchy. This perspective of person-led care differs from "patient-centered care" described in a Cochrane review by Lewin, Skea, Entwistle, Zwarenstein, and Dick (2001). The Cochrane review identifies patient-centered care as a philosophy, as a process of focussing on client preferences, and as shared control, decision-making, and management of a (health) problem between professionals and patients. The concept analysis of ethical sensitivity identifies the outcome of person-led care as based on clients' needs in addition to preferences, and as resulting from the professional making decisions and acting according to the professional's understanding of all relevant perspectives for and on behalf of the client.

The analysis illuminated the role of professional self-transcendence in the development of ethical sensitivity. Transcendence is an intellectual, reflexive process (Lonergan, 1972). The professional uses reflexivity in determining course of action and transcending old views of self and situation. As transcendence involves choosing one

from several options, it requires ability to forecast and judge an uncertain quality. In this regard, the findings of the concept analysis resonate with the work of Kahneman and Tversky (1982) who acknowledge the need to consider both singular (specific features about a particular case that distinguish it from others) and distributional (knowledge about the distribution of outcomes observed from similar situations) data in predicting consequences.

In this dissertation, I support conclusions from studies not included in the sample that professionals use different and combined strategies for decision-making. The identification of the attribute of moral perception that occurs outside of conscious processing lends support to Benner and Tanner's (1987) claim of intuition as a legitimate component of clinical judgment. The identification of the role of experience in acquiring stored templates to aid pattern recognition supports the findings of Offredy (1998) and the Manias team (2004) that experts use more intuition (making a judgment based on noncognition) and pattern recognition (making a judgment on the basis of category recognition) while novices use a hypothetico-deductive method (testing hypothesis and modifying them on the basis of outcomes).

This concept analysis enriches the findings of previous work and conceptualizations by providing rationale for the variety of strategies to achieve ethical sensitivity. The analysis of ethical sensitivity portrays the purpose of using the complex array of processes associated with moral perception, affectivity, and dividing loyalties as a way to reduce error. For instance, professionals try to get the broadest possible view of the situation by interviewing, observing, and interpreting the perspectives of all those affected in the situation. Professionals use multiple sources of

knowledge including the values expressed in professional codes and academic, clinical, and self-referential types of knowledge to judge competing claims. The results of the concept analysis depict the professional as striving to correct for bias related to threat of inadequate representativeness and knowledge. The other studies do not convey this sense of safeguarding against error. Rather, they convey professionals using certain types of decision-making merely out of preference and habit based on experience level. The conceptualization of ethical sensitivity as clinical wisdom emphasizes the need for professional attentiveness to clients, effective communication, and recognition of own limitations, values, expectations, and experience in professional decision-making.

Relationship of the Separate Articles to Each Other

Chapters 1 – 5 of this doctoral thesis report different aspects of the exploration of the concept of ethical sensitivity. They are logically ordered to convey the research process and product from the initial appraisal of the literature to the development of a framework of educational strategies for enhancing ethical sensitivity in professional courses and programs. These articles are summarized below:

Chapter One: Article 1, "Ethical Sensitivity: State of Knowledge and Needs for Further Research," is a critique of the state of the science of ethical sensitivity. From review of the professional literature, the concept is determined to be an emerging scientific concept with potential utility to research and practice. This utility, however, is impeded by multiplicity of theoretical descriptor terms, gaps in understanding (e.g., its associated negative consequences, its nature, and the role of professional socialization), and lack of scientific consensus regarding concept anatomy (e.g., definition, attributes, preconditions, and outcomes) and physiology (e.g., relation to

other components of professional decision-making such as agency). The need to explore and enhance the concept's comprehensiveness is identified.

To accomplish this aim, in Chapter Two: Article 2, "The State of the Art of Concept Analysis in Nursing," I examine the major methods used by nurses to analyze concepts. Comparison of these methods reveal wide differences in terms of study purpose, procedures, view of concepts, philosophical and theoretical underpinnings of associated research paradigms, limitations, adequacy of the direction provided to researchers using the method, and contribution to nursing knowledge. I found the well defined criteria for evaluating concept maturity (Morse, 1995; Morse, Hupcey, Penrod & Mitcham, 2002; Morse, Mitcham, Hupcey & Tason, 1996) developed within the Morse Criterion-based method have been used to evaluate the results from other methods of concept analysis. This begins to illustrate the usefulness and advantage (i.e., its intense rigor) of the Morse method for developing the nursing conceptual base.

In Chapter Three: Article 3, "Inside the Morse Criterion-Based Method of Concept Analysis: Using Analytical Questions to Explore Ethical Sensitivity," analytical questions are formulated from and can be asked of all the literature to push beyond the limits of isolated findings and individual disciplines to gain new insight, lines of questioning, and direction. This has resulted in the preparation of a set of criteria for assessing the adequacy of analytical questions and a taxonomy identifying the characteristics and boundaries of ethical sensitivity.

In Chapter Four: Article 4, "What is Ethical Sensitivity? Analysis of the Concept as Discovered in the Literature" findings from concept clarification are reported. Ethical sensitivity has been found to require exposure to suffering and

vulnerability cues, uncertainty, and relationships characterized by receptivity, responsiveness, and courage. Attributes are identified as moral perception, affectivity, and dividing loyalties. Outcomes are client comfort, professional learning and transcendence, and integrity-preserving compromise.

Chapter Five: Article 5, "Guidelines for Enhancing the Educational Development of Ethical Sensitivity," is an analysis of contemporary educational strategies for enhancing ethical sensitivity. The results provide structure and rationale for the design of appropriate teaching and learning strategies to help educators prepare professionals for ethical practice. Issues that have hindered (e.g., lack of comprehensive understanding of the concept and its measurement) and that will continue to hinder the development of ethical sensitivity in professional educational programs (e.g., limited choice of research based, scientifically sound teaching strategies) are discussed.

Each of the chapters builds on the previous chapters and what was learned from the literature. For example, the essential core of components of ethical sensitivity (i.e., responsibility, knowledge, affect, cognition, and skill) has been carried forward in the consolidated definition of the concept. Each chapter is complete enough to stand apart from the others and to be submitted to different journals for peer review. Together, the chapters provide a comprehensive exposition of the need, significance, and method for exploring the concept of ethical sensitivity, the findings, and an application to education.

Contribution of This Research to Nursing and Ethical Sensitivity Knowledge

This research contributes to nursing and ethical sensitivity knowledge in two ways: substance and syntax. It adds to disciplinary substance through systematic synthesis of academic literature about the concept's use in the context of professional practice. The findings contribute clarity to our understanding of the nature and utility of the concept. The comprehensiveness of the concept of ethical sensitivity has been increased with regard to identification of its multidimensional core of affect, cognition, skill, knowledge, and responsibility that together comprise practical wisdom. Conceptualizing ethical sensitivity as practical wisdom enables appreciation of the role of experience and self-transcendence. Previous understandings of ethical sensitivity were limited because they were based on only one or more of its component parts, and were constructed from either professional or client perspectives. This explication of the concept of ethical sensitivity offers nurses and other professionals a rich understanding of an essential aspect of attending that may influence the efficacy of care delivery.

The usefulness of the findings is enhanced through the development of (a) a taxonomy of essential characteristics defining ethical sensitivity, (b) a model of the process and components of ethical sensitivity, and (c) a framework of educational strategies corresponding to conceptual dimensions. The taxonomy is a useful heuristic for differentiating what is and is not ethical sensitivity. The model depicts the complexity of the components and processes that link together in the development of ethical sensitivity. The generation of educational guidelines helps clarify expectations and teaching strategies for developing ethical sensitivity (i.e., enhancing preconditions, attributes, and outcomes) as reported in the literature of professional disciplines.

Opportunity to augment and to challenge beliefs and extant theories is a major research contribution. This research provided several such opportunities. It revealed that the value of professional codes of ethics to disciplinary practice is poorly understood. It revealed the threat to ethical sensitive from organizational control. It supported the need for linking conceptions of ethical sensitivity with agency. Given that the responsibility component of ethical sensitivity is the basis for client evaluation of professional intent, it is not ethically defensible for professionals to "mean well" but not act wisely and in accordance with what the situation demands.

This work extends prior critique of concept analysis methods put forward by Morse and her colleagues (Hupcey, Morse, Lenz & Tason, 1996; Morse, Hupcey, Mitcham & Lenz, 1996; Morse, Mitcham et al., 1996). It has included the Morse Criterion-based method in the comparison of the methods for concept analysis in nursing, examined the philosophical underpinnings of the research paradigms, and evaluated the direction offered to researchers. It contributed to the development of criteria for evaluating the adequacy of analytical questions used to synthesize results and create new knowledge. It provided a clear explanation of how initial and analytical questions operationalize the guiding principles.

Critical appraisal using the literature of twelve professional disciplines may be seen as an example of transdisciplinary research. *Transdisciplinarity* refers to linking ideas and information across the boundaries of individual disciplines to develop a common explanation that can become shared knowledge (Glittenberg, 2004; Martin, 2003). Transdisciplinary research is more context sensitive, transient, and inventive than other types of interdisciplinary research because the knowledge produced

"transcends the disciplinary theories and paradigms from which it is in part derived" (van Manen, 2001, p. 850). Other types of research include unidisciplinary, multidisciplinary, and interdisciplinary. *Unidisciplinary* research relies on methods and theories associated with a single discipline (Stokols et al., 2003). *Multidisciplinary* refers to two or more disciplines involved in the same issue yet not necessarily interacting with each other (Scholes & Vaughan, 2002). *Interdisciplinary* research is addressing a problem common to two or more disciplines from each discipline's respective perspective (Stokols et al., 2003).

Increasingly, research granting agencies explicitly require a proposed project to develop knowledge and to work on concepts and issues pertinent to several disciplines (Sperber, 2005). The transdisciplinary character of the Morse Criterion-based method made possible the analysis of a concept of significance to many professional disciplines, enabling the development of a common conceptual comprehension that superceded available across disciplines. This was essential given that my preliminary review of the literature revealed no single discipline could provide an appropriate vantage point. The non-linear and complex transdisciplinarity processes of the Morse method enabled challenging authors' underlying assumptions and breaking free of prior categorizations to produce multifaceted theoretical description of the concept of ethical sensitivity.

This dissertation contributes five manuscripts which will be submitted to peer-reviewed journals for nursing and other professional disciplines. This means of disseminating findings offers greater accessibility and timely availability of the research to scholars, clinicians, administrators, and students of professional disciplines.

Limitations

The limitation of this research extends from the restrictions of the state of disciplinary knowledge about ethical sensitivity available in published literature from the concept's introduction to science (1982) to the completion of this concept analysis (June, 2005). Qualitative inquiry with a field work component will be needed to explore areas (e.g., Can ethical sensitivity be observed?) not well-addressed by the literature.

Future Work in Nursing Education, Theory, and Practice

Within Program of Research

It will be important to continue to study ethical sensitivity as this dissertation identifies the utility of the concept to nursing and other professional disciplines, and there is a need to build evidence by application and implementation. Without the further research, disciplinary and interdisciplinary knowledge will not be optimally developed. Findings will not reach an appropriate level to inform and benefit practice.

In the next phase of my research training, I will begin to fit the findings of this concept analysis of ethical sensitivity together with those of the MN eating disorder recovering project to enhance understanding of the phenomenon of recovering. According to Morse (2001), research results may be expanded from original study in three ways: development of a research program incrementally resolving a research problem, systematic analysis or synthesis of findings from multiple studies, and implementation. It is appropriate to develop a program of research through project fitting (comparing at least two projects to gain a comprehensive perspective) and theory construction (incorporating concepts that appear together into the same theory

by using qualitative inquiry). Theory construction may involve linking the concepts of professional ethical sensitivity and client self development in order to produce a more comprehensive qualitatively-derived theory of recovering. Linking concepts together enables verification of the concepts and increases theoretical scope and utility (Morse, 2001). Concepts are linked by opening them up to examine processes, attributes, or categories in both concepts that show the nature of their interaction. For example, linking the concept of recovering as client self-development with professional attention to "integrity preserving" person-led care may enhance understanding of how clients achieve "taking care of myself" (Weaver, 2001) in treatment settings.

The work that I have accomplished from publication of MN research and from PhD research and Video dissemination projects is illustrated in Figure F-1. Both MN and PhD research have resulted in enhanced concept comprehension. The concepts of recovering from the client perspective and of ethical sensitivity from the professional perspective have attained a higher level of development. The concept of recovering as self development has clearly defined behavioural manifestations that can contribute to informed practice. It was not possible to develop the concept of ethical sensitivity to this level from the scientific literature. The complex concept will require further exploration, this time of a qualitative fieldwork nature.

I think it crucial to enter the field to continue development of ethical sensitivity because the concept has been sufficiently clarified through theoretical study to identify areas for new investigation. These areas concern the relationship between clients and professionals and can best be observed in the actual clinical setting. The concept analysis revealed that clients can tell when professionals are not ethically sensitive.

What is the basis for this client evaluation? Is it possible to observe ethical sensitivity? Ethnographic research with intensive fieldwork in the clinical setting will further identification of behavioral manifestations of recovering. This will enhance understanding of how to assess recovering. The next phase of my research program (identified in dotted lines) will generate description of how clients and professionals experience ethical sensitivity in the context of professional-client relationships within eating disorder or psychiatric-mental health treatment delivery services. The ultimate long-term research aim is to develop theory for practice to improve the well-being of clients. It will be advanced one project at a time.

1. Practice
Staff nurse, advanced practice nurse, and nurse educator
2. MN Research
Grounded theory to develop concept of recovering (Semi-structured interviews, literature)
Dissemination & testing
*Video
*Clinical setting
Theory of Self-development
3. PhD Research
Concept clarification of ethical sensitivity
Critical appraisal of literature)
4. Postdoctoral Research
How is ethical sensitivity described and experienced by clients, nurses, and other professionals in the treatment of and recovering from eating disorders? (Observation, interview, literature, other texts)
Conceptualization of Ethical Sensitivity

Figure F-1. Emerging program of research for postdoctoral studies.

This dissertation research – a rigorous exploration, evaluation, and enhancement of the utility of the concept of ethical sensitivity to nursing and other professional disciplines – will help to underpin and direct continuing investigation of challenges to professional-client relationships that threaten client health, comfort, and well-being and downgrade practitioner understanding and responsiveness.

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Appendix A

List of Full Citations for the Components of Ethical Sensitivity from Rest, Lutzen, and Consumer Frameworks (Table 1-1)

Affect

Bebeau, M. J., Rest, J. R., & Yamoor, C. M. (1985). Measuring dental students' ethical sensitivity. *Journal of Dental Education, 49*, 225-235.

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Appendix B

List of Full Citations for the Additional Terms for Ethical Sensitivity (Table 1-2)

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Appendix C

Literature Sample for Analysis

Nursing

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